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Breast Cancer

Surgical Treatment*

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THE CURABILITY of cancer of the breast depends upon (1) the complete eradication of the disease locally and (2) the absence of metastases outside the local field at the time the patient first seeks treatment. While the first of these is the responsibility of the physician, the latter is out of his control and is dependent upon the situation and type of tumor, its duration, and the particular biological make-up of the growth and the patient who harbors it. The histologic characteristics of the tumor and its biology, although not completely understood, are probably more important in determining the outcome of any individual case than is the actual duration of a growth. In every case, however, there must be a certain actual time when cancer cells pass beyond the axillary barrier to other parts of the body. For this reason tumors must be seen and diagnosed early and treatment promptly instituted; procrastination and uncertainty have no place in the treatment of cancer. In spite of this well-known fact, marked uncertainty and indecision are commonly seen, not only on the part of the patients seeking treatment, but also on the part of their physicians. I would like, therefore, to outline a fairly simple routine which, according to our experience, can be followed in the diagnosis and treatment of the vast majority of cases of cancer of the breast in the hope that it will lead to earlier and more thorough treatment of this disease.

*From Surgical Division B-St. Luke's Hospital, New York. Read at the annual meeting of the Michigan State Medical Society, Grand Rapids, September 21, 1939.

Diagnosis

The clinical diagnosis of carcinoma of the breast may be relatively simple or extremely difficult, depending upon the stage of the disease and the experience of the examiner. However, the more expert one becomes in any given field the more one sees of early, unusual or otherwise difficult cases and his percentage of correct diagnoses may paradoxically decrease instead of increase. A solitary lump in the breast of a woman over 35, with very slight dimpling of the overlying skin and with or without the presence of palpable axillary lymph nodes, is almost certainly carcinoma. Dimpling is most easily demonstrated by lifting the breast upward with the examining hand so that the breast tissue will drag on the overlying skin. That dimpling is not a pathognomonic sign of carcinoma should be borne in mind. I have seen it diffusely over the breast in a case of chronic suppurative mastitis and in a localized form in a patient with nothing but scar tissue in the breast. Enlarged lymph nodes, unless fixed and hard, mean relatively little, as the ones which can be felt very often do not contain tumor and the small non-palpable ones very often do contain tumor. A patient with an enlarged palpable node in the axilla, even if involved with tumor, has a much better prognosis than has a patient with numerous, small, non-palpable lymph nodes which are

found by histologic study after operation to contain metastases.

Several new methods of diagnosis have been described in the past few years, notably transillumination and x-ray, the latter both with and without the introduction of contrast media; but we believe that these are only adjuvants to our other methods of diagnosis and will never replace them. We have tried transillumination and have not found it of any practical aid in the differential diagnosis of breast tumors but we have had no experience in the use of x-rays for diagnosis.

The late Dr. Frank Mathews[2] believed that the aspiration of cysts of the breast for diagnostic and therapeutic purposes was justified, and in his hands it was a safe and useful procedure. It seems to me, however, and he agreed more or less, that this is a poor thing to teach and something which should not be given wide medical publicity. Dr. Mathews was expert in the physical diagnosis of breast lesions and I doubt very much if he ever did any harm by the aspiration of lesions which he considered to be cystic. He was opposed to needling lesions which he considered solid or neoplastic and being an expert surgeon he was perfectly capable of proceeding with surgery when it was indicated. I personally have seen two patients in whom definite carcinomas were found growing just outside a cyst, the latter being smooth-walled and containing clear fluid. These were not carcinomatous cysts and the diagnosis of carcinoma would have been missed if the aspiration treatment had been used.

We therefore believe that all patients with solitary breast tumors should be operated upon for the purpose of diagnosis. Each of our patients is told that the entire mass or a portion of it should be excised, examined histologically while she is under general anesthesia, and that a radical operation will not be performed unless it is definitely indicated. No compromise whatsoever is ever made with patients who are not willing to accept this advice and follow it.

Diagnostic X-ray Examination

Pre-operative x-ray examination of the chest and spine for metastases should be made in every case and as a general rule radical surgery is not undertaken in those cases showing widespread dissemination of the disease. In certain cases, however, especially those with malodorous ulcerated growths, a simple or radical mastectomy is indicated, even in the presence of distant involvement. Any operator thinking only of his five-year statistics will shun such cases, but the true surgeon, thinking of the good of his patients, will be glad to assume the responsibility for this type of work.

Biopsy

Biopsies in our cases are taken by the surgeon with the patient on the operating table and already draped for a radical procedure. Even in very typical cases of carcinoma histologic study of a frozen section should be made before proceeding with a radical operation if a pathologist trained in this method of diagnosis is available. In a few instances radical mastectomies have been performed for benign lesions under the mistaken histologic diagnosis based on a frozen section. However, such mistakes are infrequent and do not alter our view that histologic study is still the most accurate means of tumor diagnosis.

The technic for taking a surgical biopsy for histologic study is relatively simple and can be accomplished in a very few minutes. With the patient draped for the radical operation, a portion of the tumor or the entire growth is removed through a small incision. This wound is loosely packed with a gauze sponge and closed tightly with a continuous silk suture. The suture line is then sealed with collodion. All instruments used in this procedure and any blood-stained towels or gauze wipes are discarded, the skin surrounding the incision is cleansed with alcohol and the gloves are either changed or washed in bichloride of mercury. This technic gives us adequate tissue for histologic study with a minimum of trauma and without risk to the patient.

Needle or punch biopsies are not used, as we are opposed to them on theoretical and practical grounds. Theoretically we think it is an unsound practice to needle malignant tumors of the breast or metastatic carcinomas in the axillary lymph nodes and wait several days before radical surgery, when other more direct means of obtaining material for histologic diagnosis are available. The introduction of a needle large enough to secure cells for histologic study must produce undesirable trauma and hemorrhage, not only in the growth itself but also along the line

of puncture. From the practical standpoint it must be admitted that the average physician is not technically qualified to obtain the proper material for histologic study and the average pathologist does not have sufficient experience to diagnose such material once it has been obtained. While we are willing to admit that in specially trained and unusually competent hands, both of the surgeon and of the pathologist, punch and needle biopsies have been called satisfactory, we think that the teaching of this method as a sound practice for routine use should be discouraged. Patients are repeatedly seen who have had tumors needled by variously trained physicians and surgeons without the securing of proper material for histologic study and without arriving at a definite diagnosis. Knowing the difficulty one sometimes has in securing adequate tissue at operation from very small growths hidden in a fatty breast, it is hard to see how a needle biopsy from such a breast can be accepted with any confidence. Our contention is that in any case surgery is necessary: in the first instance, in which the biopsy is negative, surgery is necessary to demonstrate that tumor has not been missed by the needling; and in the second instance, in which tumor is found, immediate radical surgery is indicated. It therefore appears that needling may be dangerous and in any case it is an unnecessary and useless procedure.

Irradiation

Pre-operative irradiation is not used because we are not convinced that it is a desirable method of treating breast cancer. Adair,[1] who had had considerable experience in this field, furnishes us with the following list of its practical and proved disadvantages: (1) pulmonary fibrosis; (2) poor wound healing, especially separation of wounds; (3) increased technical difficulty of performing the operation after irradiation; (4) increased incidence of postoperative edema of the arm; and (5) fibrosis of the arm muscles with limitation of use. In order to recommend a method of treatment with these known, undesirable results, there must be some well-known and proved advantages to offset them. This, to my knowledge, cannot be found in the literature.

The chief argument which is advanced for pre-operative irradiation is that the operative field can either be sterilized of tumor cells or that the fibrosis around the tumor cells will be so great that the risk of dissemination during the radical mastectomy will be greatly decreased. Concerning the first argument, there is no evidence to show that even half of the breasts can be devitalized of their cancer cells by pre-operative irradiation. In two hundred cases reported by Adair,[1] complete disappearance of the tumor was obtained in forty-seven, or 23.5 per cent, and in one hundred four cases with axillary node involvement, sterilization of the axilla was accomplished in eight, or less than 8 per cent. We feel that a far quicker and more sure way to sterilize a person of carcinoma of the breast locally—and this is all that is claimed of irradiation—is to remove the breast and axillary contents as soon as the diagnosis of malignancy is made. It must always be borne in mind, however, that no method of treatment will be curative once the disease has spread outside the local field.

That the spread from tumors during radical mastectomy following pre-operative irradiation is diminished or completely eliminated, is purely theoretical. Our objection, therefore, to this argument is also purely theoretical. We do not believe that the traumatic spread of cancer of the breast during a radical mastectomy which is carried out in a careful and gentle manner is a factor in the spread of this disease. We have a much firmer conviction that the trauma of every-day life, including dressing and bathing, which is daily sustained during a course of pre-operative irradiation and the period of waiting which follows, has much more to do with the spread of cancer of the breast than has the manipulation of surgery.

About two years ago I had the opportunity of seeing a patient who was undergoing a series of pre-operative irradiation for what was considered a small and operable cancer of the breast. At the time I saw her she was being hospitalized because of a rather marked erythematous skin reaction and was being demonstrated to medical students as an example of a first degree burn. Upon questioning, this patient volunteered the information that she had been instructed to rub the reddened and inflamed skin over the breast carcinoma nightly with cocoa-butter in order to relieve the discomfort and that once a week she had returned to the clinic to be examined by radiologists and a group of students to see if

the tumor had not decreased in size. Since massage and manipulation are well-known causes of tumor dissemination, it is probable that no amount of pre-operative irradiation could prevent this woman from having widespread metastases before she was even brought to operation.

Technic of Radical Mastectomy

It has often been said that the technic of radical mastectomy for carcinoma has been standardized since the classic descriptions of Halsted and Meyer. While this is true to a certain extent so far as removal of adequate skin with the breast, pectoral muscles and axillary contents is concerned, it is equally true that many of the minor technical details vary greatly, not only in different clinics but by different men in the same clinic.

There are several ways in which this radical procedure may be accomplished in a well-planned and uniform manner and it is not this with which we are here concerned. Adequate skin removal and a clean axillary dissection are what we mean by radical mastectomy and these facts cannot be varied although their modes of accomplishment may differ. What I would especially like to stress are the poor functional results which are often seen following radical mastectomies and to offer several suggestions concerning the avoidance of these undesirable sequelæ. Postoperative edema of the arm and disfiguring and disabling scars which cross the axilla are two of the easily avoided complications which follow surgery. Scars running across the axilla can easily be avoided if the original skin incisions are placed high on the chest wall so as to leave an adequate axillary flap which will heal in place on the denuded chest. The dissection of this thin flap requires time but is amply rewarded by the results obtained.

I am confident that edema of the arm can be prevented almost wholly by elimination of excessive deep scarring in the axilla. This is accomplished in two ways: (1) by sharp knife dissection without the spreading and crushing of tissues and (2) by careful strapping of the axillary skin flap into the axilla so that primary union will occur between the skin and chest wall without the collection of serum. The organization of damaged tissue and large collections of serum produce scarring in the axilla with subsequent obstruction to the lymphatic and venous return from the arm.

How Radical

Although the extent of any surgical procedure must depend not only upon the condition dealt with but also to some extent upon the age and general physical condition of the patient, we have come more and more to believe that simple mastectomy is of very limited value even in the so-called palliative treatment of carcinoma of the breast. It has most frequently been used in old and debilitated patients and also for the purpose of ridding seemingly hopeless cases of large ulcerating tumors. However, in many instances these same patients have returned months or years later with large and sometimes ulcerated local recurrences or painful axillary metastases. This, of course, is poor palliation and since elderly patients stand a radical mastectomy unusually well, age *per se* is rarely an adequate excuse for skimpy surgery. Also large tumors of months' or years' duration, although of advanced and almost hopeless appearance, are often relatively benign (otherwise they would already have metastasized widely and killed the patient before reaching such a size) and in such cases a patient should not be denied a chance of a cure through inadequate surgery. During the past few years we have had six patients with apparently advanced and hopeless breast tumors, who have remained well for over five years following a so-called palliative radical mastectomy. We feel, therefore, that the indications for simple mastectomy should be more generally restricted to the absolutely hopeless cases in which demonstrable widespread metastases may be expected to prove fatal in a relatively short time.

Postoperative Irradiation

In the past we have had no definite rule concerning postoperative irradiation and have irradiated several hundred of our patients. At the present time, however, we are of the opinion that when given it should be reserved for those patients in whom there is histologic evidence of axillary node involvement. Local recurrences in our patients without axillary node involvement have been so few in number that we have come to believe it is unwise to subject these patients to routine prophylactic irradiation of the axillæ for cancer cells which do not exist. Heavy x-ray

dosage in these individuals is not only useless so far as control of the disease is concerned but in some cases is actually harmful. Patients are repeatedly seen who have been made chronic invalids by heavy, so-called prophylactic postoperative irradiation and it is the duty of the surgeon to see that his patients who are most likely already cured of their disease locally are not further handicapped by this type of treatment.

In a few instances postoperative irradiation has caused the disappearance of local recurrences and probably prolonged life but in our series of cases we have no instance in which any patient with proved local recurrence of her tumor has been cured by irradiation. On the contrary there are several instances in which non-ulcerated recurrences have been converted into open, malodorous wounds from the injudicious use of irradiation. In these instances, also, the patient has not been cured of her tumor. The important conclusion to draw from this is that cancer of the breast must be eradicated locally if the mortality from this disease is to be decreased.

I have the impression that routine postoperative irradiation has been responsible for a large amount of poorly conceived and executed surgery in the hope that any tumor remaining after operation can be destroyed by x-ray. Experience with pre-operative irradiation has shown us that metastatic foci in the axilla can only be sterilized of tumor cells in a very small number of cases and there is nothing to suggest that this is not also true of the treatment of foci remaining after radical surgery. This encouragement of inadequate surgery is a real objection to the irradiation therapy of all types and kinds of cancers whose primary form of treatment is surgery, and one which must be met by the surgical profession at large.

One of the largest fields for postoperative irradiation is in the treatment of the pain associated with skeletal metastases. No treatment is more specific or helpful in the relief of symptoms than the irradiation of a spine involved with metastatic breast carcinoma and not only are these patients made more comfortable but their lives are actually prolonged.

Summary

Cancer of the breast is primarily a surgical disease and, beginning with the time the specimen is taken for histologic study, the patient should be in the hands of a surgeon who is competent, because of pathological and technical training, to proceed with radical surgery at the time. The average physician does not have sufficient clinical material to perfect himself in the technic of aspiration or punch biopsies and the average pathologist is not experienced in the diagnosis of this material once it is obtained. Widespread use of these uncertain methods of diagnosis should be discouraged.

Pre-operative irradiation is not recommended as its theoretical advantages are far outweighed by the well-known practical disadvantages. Careful, meticulous radical mastectomy continues to be a satisfactory form of treatment for this disease and will result in a higher percentage of cures with earlier diagnosis and more prompt institution of adequate treatment.

Postoperative irradiation is reserved for those patients with proved axillary node metastases and for local recurrences. Irradiation of skeletal metastases not only adds to bodily comfort but may also actually prolong life.

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Private Practice Essential

S. Adolphus Knopf, M.D., New York City, in a monograph entitled, "Modern Medicine in the United States —Past Achievements and Solution of Present Day Problems," points out many of the false premises under which the advocates of socialized medicine are working. An ardent worker in the field of health and medicine and one of the great specialists of tuberculosis of the day, he attacks with great vigor those who would take from the people their rights to private practice of medicine and its inherent benefits. He considers the various divisions of medicine and public health and demonstrates quite conclusively the superiority of the American Way of taxing medicine in controlling them. Reviewing the Wagner Health Bill, he brings out the fact, among others, that it does not safeguard in any way the continued existence of the private practitioners who have always brought to the people the benefits of scientific research and treatment. Also that it prescribes no method for determining the nature and extent of the needs for preventive and other medical service for which it proposes allotment of funds.

Syphilis

In Industry*

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■ A RISING TREND of interest in syphilis as a problem in industry was created with the advent of the National Campaign for the Eradication of Syphilis by the United States Public Health Service. The sudden lifting of the taboo which surrounded syphilis and the spread of information through the forum, the press and the radio led to the jitters and to hysteria among both the employer and the employee with the result that the employer, in many cases, formulated a hit and miss policy, while the employee sought employment where such a policy was not in effect.

Because of this some industrial organizations and certain branches of our Federal Government, as, for example, the Civil Service Commission of the United States, inaugurated the policy of requiring a routine blood test not only of all applicants for positions, but also all of those already employed, and refusing employment to those whose serologic tests were positive. The reasons assigned for these regulations are first, the danger of transmission of syphilis especially by the food handlers; second, a syphilitic person using dangerous machinery is a hazard to himself and to others; third, the additional economic risk imposed upon the company by the possibility that the syphilitic may become disabled directly or indirectly because of his syphilis, thus imposing upon the company or the Federal Government the burden of his care.

Attitude of Industry

What then should be the general question of policy of industry in regard to syphilis? Should blood tests be done? What in general should be the attitude toward the employee with a positive Wassermann? The Employers Liability law has forced almost all of industry to require a complete physical examination of all new applicants and frequently examination of all old employees in order to protect themselves from any further liability. Such an examination would not be complete without a blood test. Such an examination would include all executives as well as minor employees. All old employees should be urged to submit to a blood examination. This should be done by persuasion and education rather than by coercion. In intermittent illnesses following an injury, especially those which extend beyond the usual period of recovery, a Wassermann test should be done.

A routine blood test, as such, without a detailed physical examination should not be used as the sole criterion for the refusal to hire, or for the dismissal of any employee. Furthermore, a blood serologic test is not the criterion of infectiousness. During the sero-negative primary stage or during the infectious secondary relapse the test may be negative, though the patient is highly infectious. A blood Wassermann test of itself does not either establish or rule out the diagnosis of cardio-vascular disease or neurosyphilis. In both types the blood test may be negative. The diagnosis of this condition can only be established by a careful study of the physical status of the patient and in neurosyphilis by examination of the spinal fluid. One case will illustrate the futility of using the blood Wassermann test as a yardstick for employment.

R. H., aged twenty, has congenital syphilis for which he was treated for three years, at the end of which time the Wassermann was still positive. The physical examination was entirely negative. He applied for a position as a patrolman in a Police Department, was accepted and started on duty for a probation period of six months. During this period he was required to purchase all of his equipment. In the interval the Police Department passed a rule requiring a blood Wassermann. At the end of the six-months period he was reexamined and found to be physically fit except that he had a positive Wassermann. He was immediately discharged and to this day has not been able to return.

Many other examples of this type could be cited.

We believe that no applicants for positions should be turned away, and those already employed should not be discharged because of a

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positive Wassermann. It is economically impossible to discharge or refuse employment to men and women with latent syphilis. We know that about 12 million people in this country are infected with syphilis and probably one-half of that number will continue to have a positive serological test whether or not they have adequate treatment. If they have early syphilis they should be relieved from work, and treated until such a time when they are not dangerous to their fellow workers. The same scheme would apply to latent asymptomatic syphilitics who are competent to perform their jobs. Individuals with late manifestations of syphilis must be judged individually with careful discrimination. If such an employee is physically and mentally capable of assuming the responsibility of a position he should not be rejected because of his syphilis. The presence of cardiovascular and nervous system syphilis usually precludes the ability of the wage earner to perform heavy physical labor. This type should not be placed in a position of responsibility if it involves the safety of others or the manipulation of delicate machinery unless the industrial physician finds that individual qualified.

Determining Disposition of Syphilitic Persons

The question of the danger of transmission of syphilis can best be handled by dividing the workers into various groups. The first group we will call the personal service type. This group would include food handlers, hotel and restaurant help, barbers, beauty operators, pullman porters, schoolteachers, matrons, nurses and all of those whose work brings them into intimate personal relation to other people. The second group includes those who have a routine job such as clerks, laborers, helpers, janitors and operators of individual machines. The third group is of primary importance in industry. This includes the individuals who hold responsible positions such as air-pilots, railroad engineers, train dispatchers, train operators, bus drivers and also the executive with a responsibility for the managing of various enterprises.

The first group presents the greatest possibility of chance infection. The early stage of the disease is the most important when chancres, skin lesions and mucous patches appear. Latent syphilitics are not likely to transmit an accidental infection, as the individual who has had syphilis for five years is not considered infectious. The industrial surgeon who is responsible for this group of workers must keep high his index of suspicion. Every suspicious sore should be darkfielded and every skin lesion should be carefully checked. When syphilis is discovered and properly treated the period of contagion is short. On the whole it is our belief that the chance of accidental infection is very small. The second and third groups present no unusual problem of chance infection. Close contact with other employees does not occur in those groups.

From the standpoint of public safety the risk that the syphilitic person handling dangerous machinery may endanger the lives of others is limited primarily to the second group and then only to those patients with cardiovascular syphilis, neurosyphilis and general paresis. We have no available evidence in medical literature which shows that industrial accidents are more frequently due to carelessness of syphilitic persons excluding the exceptions mentioned above than are due to carelessness of non-syphilitic persons. Furthermore, public safety is not protected by the employment of non-syphilitic persons unless those persons remain non-syphilitic during the entire period of their hazardous occupation.

Risks from Syphilitic Persons in Industry

Statistics show that heart disease is responsible for more deaths than pneumonia, tuberculosis or cancer. About 10 to 12 per cent of heart disease results from syphilis. Since each death represents a loss of from nineteen to twenty-three years, it is estimated that the loss from cardiovascular syphilis is from 800,000 to 850,000 years of life annually. It is a well-known fact that heavy physical labor and great mental stress and strain is conducive to development of aortic dilitation and aneurysm among syphilitic employees. Cochens and Kemp reported the effect of occupation on incidence and type of syphilitic aortitis on 749 syphilitic males. They found 13.3 per cent with syphilitic aortic disease. Of this group 4 per cent had simple aortitis; 1.0 per cent aortic insufficiency, 5.2 per cent aneurysm and 2.3 per cent aortic insufficiency and aneurysm. Examples of this type could be multiplied many times by investigation of the auto industry, mining industry, construction, transportation and many other industries where heavy physical labor is demanded. Every syphilitic employee with

cardiac disease may thus become either a partial or a total disability and a financial liability to the company which employs his services.

The central nervous system and brain are likewise predominately affected by syphilis. The United States Bureau of Census estimates that 10 per cent of all commitments to insane asylums are the direct result of general paresis and tabes dorsalis. As in cardio-vascular syphilis, involvement of the central nervous system may remain asymptomatic for a long period of time revealing no outward signs or any mental changes. During this period it can often only be diagnosed by a spinal fluid examination. On the other hand the disease may produce symptoms at an early stage such as headaches, tremors of the tongue and lips, as well as in the hands and fingers, and changes in conduct. Early in the disease the memory for recent events becomes defective which is demonstrated by the patient resorting to written memoranda for everything he wishes to remember. They lose their mental alertness, fail to react to normal stimuli. They overlook the danger signal and thus become the cause of an accident. This type of individual lives with us and is a constant source of danger.

In tabes dorsalis we usually observe faulty coordination, ataxia, diminution in vision which frequently leads to falls, fractures and other accidents for which the employer pays claims for other than for syphilis. The employee with a partial or a total blindness is a constant source of danger not only to himself but also to his fellow workers. In our estimation this group presents the most serious problem in syphilis in industry.

Probably the greatest objection raised against the employment of syphilitic persons is that an economic risk is imposed upon the company by the industrial compensation or other forms of social insurance. It is no doubt true that in many instances compensation claims are paid for injuries which better medical advice would have set down to syphilitic infection rather than accident. At the present time we have no data to determine to what degree these cases figure in the annual budget of a large industrial organization.

Complications

Early detection of syphilis, proper treatment followed by a complete and thorough examination of the worker following injury and the proper evaluation of the Wassermann would eliminate many claims for which compensation is now paid. It has been our observation that the industrial surgeon in many cases considers the injury only instead of the general physical condition of the patient. The following cases will illustrate the necessity for careful examinations:

Case 1.—J. W., aged forty-nine, sustained an injury to the right ankle when he stepped between platform and conveyor. He complained of severe pain while walking. The treatment consisted of moist heat, elastic bandage and then an elastic stocking. In May or June, 1935, he consulted an attorney who referred him to a physician. The x-ray revealed an osteitis which on later examination was found to be a Charcot joint. The Wassermann was 4 plus. There was no history of a penile sore. He had gonorrhea in 1906. Not only compensation but treatment was ordered by the Department of Labor.

Case 2.—D. M., aged forty-six, on January 2, 1934, slipped and fell while carrying iron pipe, causing injury to lower back and right hip. The x-ray revealed no fracture or evidence of trauma. He was placed in a plaster cast. His teeth were extracted. This treatment did not relieve the symptoms. In June, 1934, he was sent to Harper Hospital for study. The Wassermann was 4 plus and the radiograph of the chest revealed the aorta tortuous. The diagnosis was cerebro-spinal syphilis. He had gonorrhea in 1916. His wife had had six miscarriages.

Page Edmund quoted by Eller reported thirty-five cases where the diagnosis included hemiplegia, sacro-iliac disease, influenza and a host of other conditions in which the final diagnosis of syphilis was confirmed. All of these subjects lost a total of 13,946 days at a total cost to industry of $50,711, not including the loss to the employee. We emphasize that any illness in an industrial worker or any convalescence prolonged beyond the usual expectancy following an injury or illness should be the occasion for a combination of a complete physical examination, repeated blood tests and x-ray examination of the injured parts and chest and a lumbar puncture.

Frequently claims for compensation are allowed on the basis of the Wassermann. The courts, Department of Labor and many attorneys feel that the diagnosis of syphilis is based entirely on the blood serology instead of a physical examination. This fallacy can be removed by proper education of court officials and attorneys; also by the appointment of a medical board to rule on borderline cases, because in many cases

a compensation award is based on medical findings. The Michigan Department of Labor requested that such a board be appointed in the various large industrial centers. The Wayne County Medical Society appointed such a group including all the specialities. Up to the present time this plan has not been put into effect.

Conclusion

In conclusion may we state that we believe the application of the principles of detection and diagnosis together with thorough and effective treatment and proper follow-up should control syphilis in industry. The Wassermann should not be used as the only criterion for employment. Accidental infection resulting from contact while at work is rare and would probably only occur in the personal service group. The syphilitic individual handling dangerous machinery does not endanger the lives of others any more than his more fortunate brother with the exception of those patients with cardio-vascular syphilis, neurosyphilis and general paresis. Finally we have no definite data that the syphilitic person, with the exception of the cardiovascular and neurosyphilis, imposes a greater economic risk upon the company than does the non-syphilitic individual.

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The New York State Journal of Medicine (Jan., 1940) states editorially, "Apart from questions rising directly from the war, however, the profession has many grave problems to face at the outset of 1940. Social and economic conditions are changing; and the traditional pattern of medical practice must be adapted to the new times without sacrifice of essential values. This requires a discriminating, determined attitude toward medicosocial legislation, with ready adoption of desirable reforms and firm resistance to changes threatening the standards and independence of medical practice. If we desire to prevent compulsory insurance under bureaucratic control, we must bend our efforts to make voluntary medical expense indemnity insurance work. If we desire to escape political domination, we must assume an attitude of constructive leadership on all questions pertaining to the public health."

Otolaryngology

Some Practical Points in Diagnosis and Treatment*

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■ IN THIS DAY of automobile and athletic sports, injuries to the ear are frequent. Never irrigate an ear which is discharging blood or fluid, following an accident.

An acute swelling of the external ear usually means blood or serous fluid has collected under the perichondrium. Unless this blood or serous fluid is removed early, and definite steps are taken to prevent its reaccumulation, softening of the cartilage occurs with a resulting cauliflower deformity (and a possible legal suit for neglect). Early, this fluid may be removed by aspiration or incision.

The most difficult part of the treatment is to apply pressure, which will prevent reaccumulation of fluid. Dental modeling compound applied immediately after aspiration, completely enclosing the external ear, is excellent. It must be divided on the third day. If serum is again present, aspirate, and reapply mold for two to three days more.

Another satisfactory dressing consists of applying layer upon layer of cotton soaked in collodion over the front and back of the ear, molding it to the ear. A hairpin is applied while drying.[1]

Cases of three to six days' standing usually require more radical treatment, if a gross deformity is to be prevented. Make an incision at right angles to the long axis of the ear through the skin and perichondrium. Insert a Gruen-

*Presented at the annual meeting of the Michigan State Medical Society, Grand Rapids, September 21, 1939.

wald punch and bite out a window.[2] Remove all clot and soft cartilage, if present, with a spoon curette. Apply a non-irritating antiseptic, and a pressure mold. I find a copper wire laid on the edge of the ear under the dental mold is helpful in dividing the mold for inspection of the ear several days after application.

Acute Infections of the Ear

Pain in the ear while chewing, accompanied by pain when pressing on the external ear, usually means a furuncle of the external auditory canal, not an otitis media. An application of 50 per cent silver nitrate, followed by a gauze wick packing of 1 per cent yellow oxide of mercury, is very helpful in these cases. Firm packing with gauze and Burrow's solution, moistened with a dropper at intervals, is also excellent. Do not forget that these patients should have sufficient sedatives to sleep. I have found that daily doses of three units of insulin seem to hasten resolution, often with surprising relief.

Many acute middle ear infections subside without rupture or incision of the ear drum and indiscriminate incision is to be discouraged. As long as the short process of the malleus is still visible, incision can usually safely be delayed. Redness and swelling about the malleus calls for heat and warm 5 per cent phenol in glycerine drops. An infant with a temperature, who cries after coughing, usually has a middle ear infection.

Acute middle ears, which come up quickly and violently, and rupture during the first twelve or twenty-four hours after onset, show hemolytic streptococci in 90 per cent of cases. Since 70 per cent of all strains of streptococci in humans are B. hæmolyticus, the results obtained by the use of sulfanilamide are excellent. If properly given, and there is no relief in three to four days, the drug should be stopped. I have seen one case, and two more cases have been called to my attention, in which the white count rose to 40,000, and 75,000, and in my case to 90,000, following sulfanilamide.

Every acute discharging ear is accompanied by some infection of the mastoid cells, and mastoid tenderness usually appears on the third or fourth day. This early tenderness, however, does not indicate need of an immediate mastoidectomy. Few primary mastoid infections require operation before ten days, and usually not before the second or third week.

Chronic Infections of the Ear

Chronic discharging ears are always dangerous. This point can not be too strongly emphasized. Small perforations high in the attic region, even though discharge be infrequent and small in amount, usually require a modified radical operation, in which the drum and ossicles are disturbed as little as possible. If with each head cold there is accompanying occipital and temporal pain on the side of the discharging ear, intracranial complications and death are impending. Do not delay operation.

Acute Infections of the Nose

It must be emphasized that a boil on, or near, the end of the nose, is indeed a very dangerous swelling. If cut into or squeezed in the early red stage a meningitis may result, for the return blood supply is largely through valveless veins to the base of the brain cavity. Compresses of aluminum acetate, or of epsom salts with a pinch of table salt added, are indicated to soften the boil before rupture or opening.

Acute Colds

Acute colds are not best treated by taking large quantities of orange juice, soda, or alkaline drinks, as so frequently advocated and advertised over the radio. The nasal and body secretions are normally slightly acid, thus offering the greatest resistance to bacterial growth. It is not generally realized that bacteria require an alkaline medium for growth. This fact is made use of in every clinical laboratory and bacteria are routinely grown on an alkaline medium. No laboratory grows streptococci on an acid medium. Is it reasonable then that we should deliberately attempt to create an alkaline condition of the secretions of the body, and thus play into the hands of our bacterial enemies? It is when the nasal and body secretions shift from their normal slightly acid reaction to the alkaline side, that bacteria, accompanying acute infection, find their favorite field for growth.

Alkaline treatment has been broadcast beyond its true value. The drinking of a level teaspoonful of ordinary table salt in a glass of cold water at the onset of a cold, even repeated several times the first day, will do much more for most colds than any of the alkaline drinks.

Cathartics, unless positively indicated, have no place in the treatment of an acute cold. They

decrease the body fluids, deplete the patient, and prolong a cold from one to two days.

Two tablespoonfuls of strained honey with the juice of one-half of a lemon in a tall glass of hot water, sipped at bedtime, is an ideal drink in the treatment of colds. Our forefathers rightfully recognized honey as a valuable adjunct in medicine.

Coughs, arising with acute colds, and lasting more than two weeks, indicate a nasal sinus infection until proved otherwise. Unless these sinuses and cough are cured, especially in young children, a beginning bronchiectasis occurs, the golden opportunity has been lost, and a condition far more incurable than tuberculosis has arisen.

Fractures of the Nose

Early or immediate treatment of fractures of the nose is most important. Do not depend upon x-ray in these cases. If there was bleeding with the injury, fracture and a tearing of the underlying membranes must have occurred. Is there a deformity, external or internal? If so, under local or gas anesthesia, push the nose in place and elevate depressed fragments by placing a blunt instrument in the nose. No splints as a rule are necessary. Look carefully for hemorrhage into the septum and drain if present, otherwise suppuration and a saddle nose deformity usually results.

Nasal Hemorrhage

Remember that 90 per cent of all nasal hemorrhages come from the anterior portion of the septum, and do not require post-nasal plugs and long strips of packing. A large piece of cotton, as large as one's thumb, placed well into the bleeding nares, with light pressure against the side of the nose to bear the cotton against the septum, will usually stop the bleeding in five to ten minutes.

After the cotton is removed, apply a 10 per cent solution of cocain, followed by using a very small applicator dipped in a 50 per cent solution of silver nitrate. Hold this applicator firmly against the bleeding point thirty to sixty seconds. This treatment will not fail you in septal hemorrhages. Vaseline following should be advised to relieve dryness.

Antrum Infection

I wish to call your attention to a procedure which I hope you will help to discourage. That is, the treatment of an antrum infection through a fistula, occurring after the extraction of a tooth. The normal route of drainage for an antrum is through the nose, and not the mouth. It would be better to suture the opening immediately to prevent further infection from the mouth, or to let a good blood clot remain as a base for healing. Treat the antrum infection through the nose.

Infections of Mouth and Neck

I wish to mention a few points which you will find very helpful in the care of infections about the mouth and neck. No attempt need be made to give fluids by mouth in cases of acute cellulitis and painful swallowing. A nasal tube inserted, and left in place, for the maintenance of fluids and nourishment is recommended. Remember, in submaxillary infection and Ludwig's angina, there is no distinct trismus. The patient may have difficulty in swallowing, but moves the jaws without pain. It is in the pharyngo-maxillary infections that trismus is most marked and is accompanied by external swelling in the upper part of the neck as well as temperature and difficulty in swallowing. Usually there is a history of extraction or infection of a lower molar, or a peritonsillar or pharyngeal abscess.

Very definite treatment is indicated in these cases to save their lives. First, x-ray is helpful in early localization. Second, there are two very definite, but not too difficult, methods of approach for entering and draining the pharyngo-maxillary fossæ. First, incision through the anterior tonsillar pillar,[3] and insertion of an eight inch hemostat, preferably curved, is an excellent and simple procedure in many cases. Second, the Batson approach, in which an incision is made just back of the angle of the jaw. Find this angle with your finger and enter with hemostat or finger deep to this angle and upward. You will easily enter a free cavity just lateral to the tonsil.

Ludwig's angina is always alarming and definite in picture, with a brawny tender submental swelling, often with the tongue pushed high into the mouth, or even protruding, accompanied by difficult swallowing, and threatened breathing. X-ray treatment helps in localization, and I have

seen cases, even with the tongue much elevated, subside after x-ray treatment. I wish here to condemn the old ear-to-ear incision in the treatment of these cases. It is an incision of horror, and results in much unnecessary scarring. If the infection is chiefly above the mylohyoid muscles, drainage by incision in the floor of the mouth is excellent and sufficient.

The external incision, when desirable, should be made carefully in the midline, not to the right or to the left. From this incision a hemostat can be passed to either side below the mylohyoid muscle, or, by advancing the mid-incision through this muscle, both sides above the mylohyoid and in the floor of the mouth may be reached.

556 Doctors' Building.

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Group Hospitalization

The Michigan Society for Group Hospitalization announces that nine months from the date of issuance of its first contract they have over 70,000 subscribers.

"The rapid expansion of the organization may be attributed to a large extent to the enthusiastic coöperation accorded the plan by the physicians of the state.

"Executives of over 550 leading Michigan organizations have already made this plan available to their employees. The fact that about 55 per cent of the workers in these organizations took advantage of this opportunity to enroll is ample evidence that there is a definite need and desire for this protection among the people of the state

"With service, not only to the subscriber but to the hospitals and doctors as well, as its basic principle, the Society has taken every precaution never to interfere in any way with existing relationships between physicians and hospitals or between physicians and patients.

"Under the provisions of this plan, the subscriber may receive hospital care only on the recommendation of his physician. When, in the attending physician's judgment, hospital care is no longer necessary, only he can order his patient discharged.

"During the few months this plan has been in effect in the state, the many doctors who have recommended hospitalization for subscribers have realized what a blessing this service is to their patients. A patient whose mind is free of anxiety over expense incurred during a stay at the hospital is apt to experience a more rapid recovery than one who is constantly worrying about a mounting hospital bill. Also, with his hospital bill taken care of, the patient finds it much easier to pay his physician.

An Improved Needle

For the Injection of Internal Hemorrhoids

By Constantine L. A. Odén, M.D.
Muskegon, Michigan

CONSTANTINE ODEN, M.D.

University of Wisconsin, 1918, B.S.; New York University, 1920, M.S.; Bellevue Medical College, 1920, M.D.; Interne Bellevue Hospital, 1920-1922; Assistant to the late Dr. A. J. Ochsner, Augustana Hospital, Chicago, 1922-1923; Attending Surgeon at Hackley and Mercy Hospitals, Muskegon, Michigan; Non-resident Fellow of the Chicago Surgical Society; Associate Fellow of the American Proctologic Society; Fellow American College of Surgeons.

■ THE injection treatment of internal hemorrhoids definitely has its limitations, and these should be understood by each practitioner before attempting to perform this very important operation. Unfortunately, because the procedure seems easy it is being used too extensively and in many conditions where it is wholly unsuitable. Faulty technic produces very unsatisfactory results and a variety of complications. It is, therefore, of paramount importance for those who wish to inject internal hemorrhoids properly to acquaint themselves with the anatomy and diseases of the anorectal regions.

Indications and Contraindications

The indications for the injection therapy are clear, the purpose being in most cases to check bleeding. The uncomplicated, bleeding, easily reduced piles of moderate size may be injected. However, when there is considerable protrusion associated with bleeding, the patient should be informed that the bleeding might be arrested, but the protrusion will probably not be completely relieved, and may return.

The contraindications are numerous. Any evidence of a recent or old inflammation of the lower intestinal tract and anorectal regions definitely contraindicates injection therapy. Pathology, such as cryptitis, papillitis, fissures, fistula, ulcerated and fibrosed infected piles, peri- and rectal abscesses, severe colitis, definitely precludes the employment of injection. *Never inject external piles.*

In males it is well to remember that in the presence of advanced prostatic hypertrophy, this obstruction should be relieved before hemorrhoids can be treated. Often they will subside if the prostate is treated or removed.

Technic

It is absolutely necessary to have proper instruments. Each patient should be proctoscoped to rule out higher pathology, therefore the first important instrument is a good proctoscope. Sev-

Fig. 1.

eral different size anoscopes, such as the Hirschman or Brinkerhoff specula, and a good light which will properly illuminate the operative field are necessary. Proper needles and syringes are very important.

I have used numerous needles of various shapes and designs, which led me to design what I consider an improved needle. Through the courtesy of the MacGregor Instrument Company such a needle has been made for me (Fig. 1), and I find it makes for better visibility, greater ease and exactness. I use a 3 c.c. syringe to which this needle is attached. The needle is so curved towards its tip that it will slightly depress the hemorrhoid, allowing its base to be injected under full vision, the bevel of the needle being turned upward instead of down as in other needles of similar design. This allows the mucosa to be more easily entered and the solution injected between the veins entering the hemorrhoid.

The solutions to be injected vary with the operator's choice. I prefer the use of 5 per cent phenol in oil combination; in other cases I use quinine-urea, depending upon the requirements of the case. The injection should be performed slowly. The hemorrhoid should not be blanched, only distended. To do this does not require a large amount of solution. I never inject over 2 or 3 c.c. of the oil solution, more often less, perhaps .5 to 1 c.c. The needle should be left in for several seconds to prevent leakage. There should be no pain. It is better to inject only one hemorrhoid at a sitting, and if a re-injection of the same hemorrhoid becomes necessary, this should be done only when induration has subsided. When injecting the hemorrhoid it is good technic to aspirate to ascertain that one is not in the blood stream. In most cases, six to eight treatments will be sufficient. It is important to keep proper records of hemorrhoids treated, strength, and amount of solution injected.

Summary

In properly selected cases, using good technic, with adequate instruments, the injection of uncomplicated hemorrhoids relieves bleeding and restores mucosa to a nearly normal condition. The introduction of a new hemorrhoid needle simplifies the technic by giving more visibility with easier entrance into the mucosa.

Pyuria

Its Diagnostic Significance*

By B. C. Corbus, M.D.
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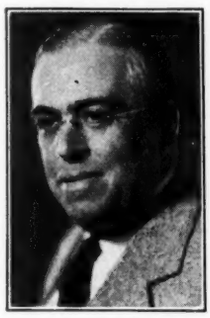

Budd C. Corbus, M.D.

Formerly Professor of Genitourinary Diseases at University of Illinois. Formerly Instructor at Rush Medical College, Chicago, Ill. Founder of the Illinois Social Hygiene Dispensary, Chicago; Director of the Evanston Social Hygiene Dispensary, Evanston; Attending Urologist at Evanston Hospital; Collaborator Cabot's Textbook of Urology; Collaborator History of Urology, American Urological Association, member of American Urological Association.

Pus in the urinary tract is one of the most common complaints that occur in the general practice of medicine. By means of the modern diagnostic methods with which the specialist in disease of the urinary organs is familiar—cystoscopy, urethroscopy, and x-ray examination of the kidneys and bladder—it should not be so difficult to discover its exact cause or source, provided a systematic method of procedure in hunting for the original source of infection is closely followed.

Infections of the urinary tract are considered as coming from two sources, *i.e.*, (a) from outside of the body, and (b) from inside the body (Fig. 1). The most common infection that occurs from without the body is gonorrhea. It has been estimated[5] that there are in the United States every year over one and one quarter million new cases of this type of venereal disease. Other less common sources of infection coming from outside are often due to instrumentation and

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catheterization following the passage of sounds or withdrawing urine when an individual is unable to pass it spontaneously. This frequently occurs following operations or childbirth. Strong antiseptics may also by their destructive action

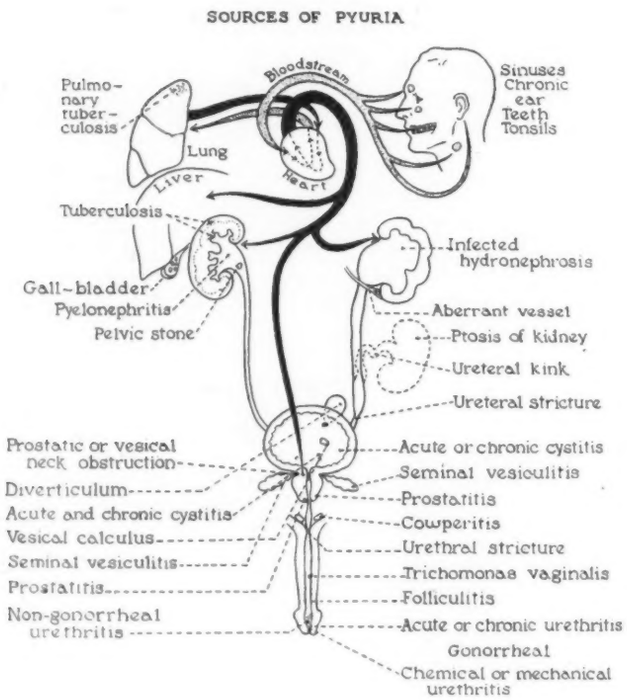

Figure 1.

do the same. Infections occurring from within the body are most frequently caused by abscessed teeth, infected tonsils, sinuses and chronic otitis media. In older individuals, the gallbladder may be the source from which pus is absorbed.

Tuberculosis of the urinary organs is always an extension from some source (most commonly in the lung). The bacilli are carried by the blood stream to the body filters, where they produce secondary abscesses, which in turn cause pus to be present in urine. The same procedure is equally true of other organisms that come from teeth, tonsils or sinuses, but they are often not so destructive in the kidneys and bladder. However, they all produce pus in the urine. Congenital or acquired obstruction to the normal flow of urine is always sooner or later associated with pyuria.

Man's urinary system may be compared to the modern installation of plumbing. As long as there is free and unobstructed drainage, the plumbing works efficiently, but if the drainage becomes obstructed, the outflow is immediately interfered with and infection is given a foothold.

Non-gonorrheal Urethritis as a Symptom of Pyuria

Examination of the literature during the last fifteen years reveals little of importance with regard to the etiology of non-gonorrheal urethritis except those infections that are secondary to stricture of the urethra or infections of the prostate and seminal vesicles. However, during the last few years our attention has been called to the fact that trichomonas vaginalis, so common in the female, is often the cause of a severe urethrocystitis in the male. The diagnosis is made by utilizing the hanging drop method from a specimen prepared from the fresh pus diluted with normal saline solution or from material obtained after centrifuging the urine. The removal of the source of infection is the only guarantee of a cure. Often when pyuria is present with its accompanying urethral discharge in either male or female, the urethra and bladder are treated diligently. We must not forget that cystitis *per se* does not exist and that instillations and irrigations of the bladder only aggravate the condition after seemingly alleviating the symptomatology.

If there has been a history of a previous gonorrheal infection the patient is often examined for stricture and frequently sounds are passed to the limit of tolerance. If, by chance, pus has been expressed from the prostate, it has been massaged diligently and often the seminal vesicle is included in the endeavor to stop the urethral discharge, each urologist indulging in his own particular hobby.

Recently O'Conor,[4] in his experimental work, has shown the following:

A dog's prostate removed after daily massage for seven consecutive days shows many areas of complete rupture of the alveolar walls together with scattered cystic formations of the alveolar spaces and a thickening of the septa with areas of round cell infiltration denoting glandular destruction and chronic inflammation. With the foregoing in mind, let us put the soft pedal upon prostatic massage in the male as a cure for pyuria of unknown origin. In tracing the source of pyuria it is a good rule, whenever possible, to make

a direct smear from the urethra in either the male or female, including Skene's and Bartholin's glands and the cervical canal in the female. As has been previously stated, the most common infection that occurs from *without the body* is gonorrhea. A diagnosis here depends upon the findings after culture or smears have been made. The following is a rapid Gram stain that we have found valuable in our practice during the last several years.

Six wide-mouthed, four-ounce bottles are numbered from 1 to 6 and labeled according to the following ingredients: Bottle 1 contains alcohol-saturated gentian-violet with distilled water in the proportion of one part stain to three parts water. Bottle 2 contains plain distilled water. Bottle 3 Gram's solution. Bottle 4 absolute methyl alcohol. Bottle 5 plain distilled water. Bottle 6 dilute Ziehl-Nielsen carbolfuchsin (about 1:10), whose speedy and penetrating properties are well known. The elements of the stain differ from the original technic in two essential details, namely, the employment of plain water for the gentian solution in place of anilin-water (this may be used nevertheless), and, most important, the substitution of absolute methyl alcohol for ethyl alcohol, as the destaining agent. The reason for this substitution is that the former acts far more quickly and efficaciously, thereby featuring a desirable time-saving phase.

In performing the Gram stain, the slide is dipped into Bottle 1 for from five to ten seconds with constant stirring, is transferred to Bottle 2 for a few seconds, excess water being taken off, then to Bottle 3 for five seconds with constant agitation to slide, thence to Bottle 4, where it takes but a few seconds to destain, especially if stirred, then transferred to Bottle 5 to wash (if it is not yet destained, the slide is returned to Bottle 4 again) and lastly to Bottle 6 for a couple of seconds. It is washed off in tap water. The staining and counterstaining, it will be seen, have been performed in about one minute.

It will be noticed that after staining with gentian-violet the slide is washed in water. According to good authorities, washing the slide with water before destaining is permissible in the employment of the Gram stain. My reason for using Bottle 2 is that by washing off excess stain the precipitation of the Gram solution is minimized. Finally, the only frequent change necessary is that of the wash-water, since the gentian stain itself does not deteriorate rapidly.

The ingestion of excessive amounts of alcohol is extremely irritating to a previously infected urinary tract. Pyuria with its accompanying non-gonorrheal or non-specific urethritis may make its first appearance following alcoholic excess, often accompanied by coitus. As a result the patient rushes to his doctor because of a guilty conscience and a slight discharge. In view of the large number of exposures to non-gonorrheal organisms to which the average urethra is subjected, infections from *without in* should be more common than from *within out,* but they are not, because the urethra is more vulnerable to this class of infection and, in addition, the passage of the urine along the urethra has a tendency to wash away the infection.

Pyuria caused by chemical or mechanical irritants is transitory and disappears as soon as the cause is removed.

Having proved that the source of the infection in the urinary tract has not come from an outside source, urine culture is indicated. If possible, the specimen of urine should be concentrated and held at least three to four hours. When repeated positive cultures are obtained, regardless of the absence of symptoms, complete investigation of the upper urinary tract should be made. This includes either excretory or retrograde urography or both.

Obtaining the Urine for Culture

For ordinary microscropic and chemical analysis, the female patient is instructed to take a vaginal douche and a bath before voiding in the morning. Often due to the contamination of both rectum and vagina a simple voided specimen is almost valueless. In obtaining a specimen for culture in the female the parts should be first scrubbed with soap and water and then irrigated with bichloride of mercury 1:5000, then dried, and preferably a glass catheter used to withdraw the urine. Always permit about one ounce to escape before collecting the material for culture.

Collecting the Specimen in the Male.—The penis is thoroughly scrubbed with soap and water, then sterilized with bichloride of mercury 1:5000, taking care to wipe the excess from the organ with gauze. The first ounce of urine voided is permitted to escape. This gives a specimen that is practically free from urethral contamination. Again, we must not forget that inflammation of the bladder *per se* does not exist. If we have a cystitis present it comes from either outside the bladder or the upper urinary tract.

Tuberculosis as a Cause of Pyuria

Almost all urinary infections are accompanied by some frequency and urgency. When we find a given case in which no organism or bacteria can be demonstrated by the ordinary methods, diligent search should be made for the tubercle bacillus. We have, according to Herrold,[2]

found the culture method on egg media preferable to guinea pig inoculation.

Ureteral Stricture

Ureteral stricture is either congenital or acquired. Young,[6] in analyzing the cause of 165 cases of hydronephrosis, mentions ureteral stricture as the etiological factor in thirty-seven instances. In our hospital and private practice ureteral stricture with or without demonstrable focal infection is the most common contributory factor in the cause of pyuria.

According to Hunner,[3] ureteral structure is an intrinsic disease of the ureteral wall resulting in a narrowing of the lumen which leads to varying degrees of urinary stasis. The more chronic type of ureteral obstruction is often very difficult to diagnose and it is here that the acumen of both physician and urologist is best tested.

In the female when there is a history of vesical irritability at the menstrual period together with abdominal pain in either side, a history of chronic appendicitis is significant, and also indicates a necessity for a complete urological study. If obstruction exists in a ureter and is constant, one should be able to demonstrate it in a ureterogram, and until such evidence is supplied I do not believe one is justified in concluding that stricture is present in a given ureter. Of course, one's ability to interpret a ureterogram is in direct proportion to his clinical experience.

Focal Infection

I believe that there is still too little attention paid to the rôle that focal infection plays in the production of chronic urinary infection. The mere fact that adequate drainage is established is not enough. Furthermore, it is useless unless the primary source of the trouble has been eradicated.

As all upper urinary tract infections are severe afflictions which ultimately totally incapacitate the patient, careful search should be made for focal infection and its source removed as soon as possible.

I am in accord with the statement of Bumpus and Meisser[1] that devitalized teeth without definite bone changes, and apparently normal tonsils, can produce focal infection.

Occasionally I have found that if all foci of infection are removed a pyuria will clear up by itself; if not, further study should be made.

Conclusion

1. From the evidence herewith presented, it appears that most pyurias of bacterial origin occur as a result of infections carried from *within out* and not from without in.

2. From the information obtained by divided urine cultures and pyelographic studies, it can be demonstrated that focal infection with poor kidney drainage is often the cause of persistent pyuria.

3. Treatment should include removal of focal infections and the establishment of adequate drainage by periodic ureteral dilatation in those cases of demonstrable obstruction, or surgical removal of any underlying pathology.

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Surgical "Catgut"

The Committee of Revision of the Pharmacopœia of the United States of America announces the new standard for surgical guts. Any suture marketed and labelled Surgical Gut, or "Catgut" Suture, or Surgical "Catgut" and intended for surgical use must meet the U.S.P. requirements, as under the Federal Food, Drug and Cosmetic Act of 1938. These standards include sterility, tensile strength, length and diameter, absorption. These standards have been prepared by the Revisory Board with the coöperation of the officials of the Public Health Service, the Food and Drug Administration, the Surgeons General of the Army and Navy, representatives of the American College of Surgeons, the American Hospital Association and the American Medical Association and a number of additional surgical and hospital groups. There has also been valuable coöperation from the manufacturers of surgical products so that the announced standards are believed to be representative of the widest experience and best known methods of production.

The Answer

Lowell S. Selling, M.D., Ph.D., of Detroit, has two articles in the *Journal of Criminal Psychopathology* for January, 1940. One entitled, "A Preliminary Report Concerning Mental Pathology Found in Automobile Drivers," and the other, "Personality Traits Observed in Automobile Drivers." These point out some of the interesting findings in Dr. Selling's campaign for prevention of accidents by eliminating the psychiatrically unsafe driver from the street. They provide most interesting reading and answer many of the questions asked as to why some drivers act and drive so peculiarly.

Endocrinology

Its Application to Human Needs*

By J. R. Goodall, M.D.
Montreal, Canada

JAMES R. GOODALL, M.D.

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■ The subject of endocrinology is a modern science, and our knowledge of it is quite incomplete. As a consequence, any deductions drawn today may have to be modified tomorrow owing to some new concept. It is a long subject. No one had any idea, at its conception, that it would reach such proportions of importance in the economy of the body. One wonders today how we ever practiced medicine prior to the new awakening. It would be futile to attempt to cover the whole subject of endocrinology in the time at my disposal, but there are certain phases of the subject that are purely clinical, and have stood the test of practical application. It is my purpose today to discuss two complexes only of this subject. By the term complex, I mean that uniglandular dystrophies are a rarity. The vast majority of gland dystrophy cases are inherited tendencies, and are pluriglandular or gland complexes. We have gone into this subject rather intensively in two hospitals under my supervision, and I am giving now for the first time the fruits of this work.

First of all, let me deal with a few generalities in glandular disease. Sufficient attention has not been given to the distinction between glandular fatigue and glandular exhaustion. Yet this very distinction is of primary importance. Fatigue arises out of the effect of excesses—long continued or short intensive excesses—upon a glandular system possessing a subnormal reserve, and all its behooves us to do under these circumstances is to change the "circumstances" of environment, or what some prefer to call "activity"—using the term to cover all incoming impressions and outgoing forces. Anyone may at some time be the subject of glandular fatigue, and it behooves us to recognize this as early as possible, in its incipient stage. Exhaustion, on the other hand, implies an hereditary low reserve, and that at any time in life; even in embryonic life this reserve may become a bankruptcy. Here, change of circumstance at the first signs of the bankruptcy may delay the symptomatic display but it will never cure it, for the source is irremediable and fixed.

Another generality of gland activity lies in this, that each gland has a history in evolution and each has a part to play in evolution. As a consequence of this we recognize that glands that had to do with the early evolution of man may run their full gamut of activity in embryonic life and disappear before birth; others serve their purpose and play their part in the body economy during childhood and become inactive; still others enter our life actively at puberty and cease at maturity, and so does the evolutionary build-up go on until the postmaturity stage, when a general decline of glands sets in, and with this decline tissues lose their resilience, and though receptivity may continue and judgments weighted with wisdom may flow from accumulated experience, the responses to impressions are slowing down and life is passing into the sedentary stage.

As previously stated, I cannot cover the whole subject, but will deal with two interesting complexes that have come out of our clinical studies, studies that have given me and my staff the most brilliant recoveries in our whole life's medical experience.

The first is the thyro-gastro-hematic complex, and the second the pituitary-thyro-ovarian-uterine complex.

Thyro-gastro-hematic Complex

I may state that since the inception of our new plan in hospital surgical practice, almost every case that is not an emergency is subjected to a blood picture or hemogram test, to find the cell content, cell characters, color index and white cell shift to right or left, if at all. A shift to the right is frequenty eloquent of an endocrine disturbance. The blood sugar a.c. and p.c. are

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taken. The basal metabolism rate is estimated, and if necessary, repeated, and the gastric acidity, both total acid and free hydrochloric acid content are estimated, with the stomach at starvation and hourly after food.

Clinical Findings

What have been the clinical findings? Generally, where one of these tests prove abnormal, they are all similarly involved. A low thyroid is commonly associated with complete achlorhydria, or by a degree of hypochlorhydria, and the absence of this gastric factor prevents the proper digestion of the proteins and causes the absence of that hepatic factor which is stored up in the liver and is liberated when needed and in sufficient quantities to stimulate the hemopoietic structures of the body into activity, to maintain a normal hemopoiesis. The absence of this factor invariably leads to an anemia, most frequently of the hypochromic type in women. And all my remarks have reference only to women. Of men's corresponding conditions I have small knowledge. Associated with these conditions one frequently finds various degrees of glycemia, sometimes present temporarily with recurrences, or grave permanent types even to the degree of gangrene. We frequently find, associated with these, periodic albuminuria. Now, what are the conclusions that one can draw from these findings, and what clinical results can one expect by corrective treatment? Let us try to reproduce our line of reasoning. We have found a hypothyroidism, archlorhydria, hypochromic anemia, and degrees of glycemia, albuminuria, and abnormal blood pressures. We have found also that these conditions are *commonly* associated in the same individual. Which is cause and which effect in this series? For they cannot be all causes, and when commonly associated they must bear a relationship. What is this relationship? First of all, accept the above facts. The symptoms will be dealt with later. Let us try to unravel this coincidence. We have proved time and time again that the absence of hydrochloric acid is the cause of the glycemia, and that this condition of the blood and its hepatic antecedent is dependent upon the achlorhydria. In two of our cases foot gangrene disappeared as if by magic without other treatment than the administration of HCl, and glycemia has disappeared in grave cases completely under this treatment, and this treatment only. It will be found that associating the hydrochloric acid with iron and thyroid hastens recovery very materially. Ferri et ammonium citrate in 30 grain doses in sherry, or in a glass of milk, has proven the most satisfactory form of administration. Gastric and intestinal flatulency disappear, and the hypochronic anemia promptly is relieved. A high protein diet is recommended.

Allergic Manifestations

Probably the most astonishing results that have flowed from these abnormal findings is the cure of allergic manifestations in patients who have been victims of the various manifestations of this malady for years. If you find this combination of endocrine dystrophies in an allergic patient you can assure them with almost 100 per cent assurance that their allergy will disappear when all other forms of treatment have failed. On the other hand, allergies without these dyscrasias cannot be given any assurance upon this score. It is remarkable how allergic colitis disappears and the most obstinate constipations, amounting in some cases to obstipation and associated with megalocolon, respond magically to this treatment and the colonic distension disappears promptly, as seen in barium-enema-x-ray visualization. Many forms of dysmenorrhea and allergy of the pelvis respond promptly to the treatment. When we find healing retarded in postsurgical cases, the finding of this syndrome of endocrine dystrophy will bring about prompt recovery with appropriate treatment. In one of the hospitals under my supervision, we are operating almost daily and in the past three years we have not had one death by any member of the staff until a few weeks ago. This was a death on the table due to cardiac block or anesthesia. Our astounding results we attribute to our pre-operative care and examination, and to the correction of corrigible defects before operation. We feel that the time to find out patients' defects and weakness is before surgical intervention. We find that any glycemia above 135 deserves treatment before operation, and intravenous glucose injections in these cases should be accompanied by small doses of insulin. Personally, I think a glycemic case treated by insulin before operation is a better surgical risk than a normal case, and per contra an elevated (ever so slightly) blood sugar is one

of the worst surgical hazards, and is often the unrecognized cause of infection and retarded healing. But it is in obstetrics that this endocrine complex is so frequently met, and gives such brilliant results.

Association with Pregnancy

In a work published by myself and Gottlieb upon the association of hypochromic anemia and pregnancy, it was found that a very large percentage of cases, especially in multiparæ with numerous pregnancies, suffered from grave degrees of hypochromic anemia, and that this condition ordinarily passed off rapidly in the first weeks of the puerperium. As was expected, the anemia was always associated with complete or a degree of achlorhydria, and the acid usually returned also in the first weeks after delivery, except in the graver cases. I have gone further since then and have also found that in most of these cases there is an associated hypothyroidism. So here again we meet with this pluriglandular association. This association is not fortuitous but recurs so frequently in combination that they are interdependent. We claimed that the hypochromic anemia was due to the demand of the fetus for iron to elaborate its own blood. Whether that is true or not, we may use the same argument in the case of the maternal athyrea. In a noteworthy case admitted to St. Mary's Hospital, the patient, a young woman six months pregnant, was diagnosed as cardiac by one doctor, as renal by another, owing to her generalized edema and dyspnea. On entering the hospital I saw her and pronounced her a grave anemia of pregnancy. Hemoglobin 20 per cent, R.B.C. 1,700,000, B.M.R. —18, a high blood sugar, 140 p.c., and achlorhydria. At the end of the first week of thyroid, hydrochloric acid, iron, and a high protein mixed diet, her hemoglobin was 28 per cent and R.B.C. 1,800,000; at the end of the second week, 48 per cent and 2,700,000; and at the end of the third week, 58 per cent and 3,200,000. The change was phenomenal, not only as regards the rapid disappearance of the edema and anemia, but more so in the improvement in the patient's mental state and in her outlook on life.

Quite recently, I undertook the study of heartburn in the last months of pregnancy. My private patients coöperated wholeheartedly in my request for investigation. Twenty cases in all were sent to the hospital, where a B.M.R., gastric acidity, and a.c. and p.c. sugar tests were done. The results confirmed my suspicions. Eigheen out of the twenty cases of heartburn had a low basal rate and achlorhydria, or marked hypochlorhydria. The other two had hyperacidity. In all of these cases of achlorhydria the total acidity of the stomach was well developed, ranging from 20 to 40 per cent, but it was composed entirely of the acids of fermentation. Treatment by HCl relieved the distress and the distension with promptness. In the cases of hyperacidity the HCl aggravated the symptoms. Here is the clinical lesson. In 90 per cent of cases, heartburn is due to lack of HCl and the consequent producing of acids of fermentation. Soda bicarbonate, which is the common domestic remedy, gives temporary relief only, by neutralizing these acids, but it also creates a medium favorable for further development of fermentation, and it is only a short time before the acids are again in the ascendant. A good clinical test is to try the HCl, 5 to 10 drops in a glassful of water after food, and if the condition is one of achlorhydria the distress will disappear promptly. If aggravated, then revert to the alkalies.

I have been under the impression for a long time that the presence of HCl is necessary, not only for the complete digestion of proteins, but also for the normal operation of vitamins, and that no matter how much we may increase the vitamins in the diet, their action is restricted by the gastric defect. That is for the future. But I am convinced, however, that the high incidence of pyelitis and cholecystitis in pregnancy is due, not to changes in intra-abdominal pressure, but to the lack of the sterilizing effect of HCl, in permitting undigested proteins to pass on into the small bowel, thereby favoring the abnormal growth of bacterial flora, and permitting absorption of these and causing them to set up cholecystitis and pyelitis in the process of elimination, for be it remembered that in both these channels there is a relative stasis owing to pregnancy, and where stasis exists, conditions favorable to infection also are present.

Speculation

Let us philosophize for a moment and step into the realm of speculation. We do know that pregnancy causes more change in the glandular system than in all the other organs, the uterus be-

ing expected. Physiologists tell us that fetal cell activity is twenty-five times more rapid than that of an adult. From this we may form some vague idea of the amount of thyroid that the fetus consumes—a consumption that must be supplied wholly by the mother until the fetal thyroid begins to function. Many of the cases of hyperthyroidism are improved during pregnancy, owing to the fetus using up the excess of the maternal elaboration. Now, I ask you to visualize the effect of this combination of hypothyrea, achlorhydria and hypochromic anemia upon the growing fetus. Not to speculate too widely, let us try to imagine the effect or effects of maternal hypothyroid upon the fetus. The fetal demand will further exhaust the maternal production, and the effect, I assume, would be a premature activity of the fetal thyroid, premature hypertrophy and, in all likelihood, an early exhaustion, or, at least, an instability. Thyroid dystrophies have a peculiar tendency to become hereditary, and are we not to blame in not supplying the deficiency in the mother in the hope of averting the exhaustion or the low reserve of the offspring's glandular system? Are we not condemning that child to a tempo of life below the normal and thereby handicapping it in the race of life? I feel very strongly that prospective mothers who come to us to know whether they can bear children do not receive an adequate answer. Most of our examination has been directed towards the question whether she can put a child into the world—in other words, what is the conformation of the pelvis? Can she stand the strain? The much more important question is, can she produce an endocrinologically normal child? No greater boon can be given a child by its parents than a large reserve of glandular power. That means muscle reserve, brain reserve, stamina and equanimity, from which emotional control, one of the greatest gifts, naturally flows. I am convinced that there is no such thing as neurasthenia. Neurasthenia is an expression of exhaustion of reserve and a draft upon capital. The field of neurasthenia is gradually being restricted as our knowledge of endocrines is increased. It will shortly be recognized as but a cloak to cover hereditary and acquired dyscrasias.

These thyro-gastro-anemias deserve a better recognition, not only in the interests of the mother, but especially of her offspring.

The Pituitary-thyro-oöphoro-uterine Complex

If the thyro-gastric complex is an enigma in its interpretation and application, this last complex is one that is still a snarled skein. As yet, we are far from a clear understanding of the intricacies of the relationship of the anterior pituitary and the ovaries, and still farther from a working rule. We do know that the anterior pituitary is the master gland of this complex; that it has the power to urge or restrain ovarian function as a charioteer in the guidance of his steeds. When the charioteer is a master of his technic, possessing, as all masters must, a large reserve for emergencies, then his schooling of his steeds is so perfect that further interference is minimal, and only disturbs trained coöperation. So it is with the pituitary. But conditions are not always so unobtrusive. The ovaries, the steeds, may not have that reserve so essential for emergencies. The charioteer may be using all his power at most of the time, leaving nothing in reserve for emergencies. So it is with this complex. Prolan A and B are the active agents in the pituitary's relations with the ovary. Prolan A is the activator of the Graafian follicle. B is the motivator of the corpus luteum. In the vast majority of instances, fortunately, the motivation is normal in its intensity. But research has shown that where defects arise in this relationship it is nearly always due to a lack, rather than to an excess, of prolan influence. Let us now consider the ovary. In this organ, I need hardly mention that estrin is the extrinsic power of the follicle. Extrinsic in the sense that it is through estrin that the Graafian follicle exercises its influence at a distance; and, similarly, that it is progesterone which plays the same rôle as regards the corpus. Now, both these endocrines must be in a certain quantum in the body to produce results, and these results are the uterine changes of the menstrual cycle, sufficient unto normal nidation and normal procreation. One of the difficult problems of this complex is to establish which is the primary gland at fault, the pituitary or the ovary. To simplify this matter it has been proved that most of the pituitary defects in this relationship are those of insufficiency of the gland. The symptoms elicited by this defection are well known. But just here enters a weighty distinction. Insufficiency of the pituitary motivation may manifest itself only at the developmental

stage of puberty, when the real test of pituitary efficiency in this respect is called into play. Or pituitary insufficiency may manifest itself after full pelvic development has been effected. The results are quite different. In the one, which is usually hereditary and is in the class of exhaustion, lack of development of the sex organs, retarded puberty, retarded menses, oligomenses and sterility are the rule. Other associated pituitary deficiencies, such as changes in secondary sex characteristics, hirsutism, abnormal distribution of fats, et cetera, may develop. In these cases of primary pituitary defect, treatment with pituitary extract is difficult and must be continuous. I have taught many of these cases to use the syringe with the same meticulous care as one instructs a diabetic in the use of insulin. The results have been most astounding in these cases, causing recession of the abnormal growth of hair and the return of many of the characteristics of feminism, for which the patients are extremely grateful. But one soon reaches a stage when improvement no longer follows and, upon stopping the treatment, relapse is the rule. Of course, there are minor degrees of deficiency where improvement is quasi-permanent, and where treatment, like "setting-up exercises," has caused at least a temporary self-sufficiency of the pituitary.

The major cases of pituitary deficiency are easy of recognition; not so the larval states. Most painstaking history elicitation and a psychological penetration are prerequisites for the recognition of these cases.

Endocrine Balance

The normal balance in the estrin and progestin elaboration and their synchronism are problems of first magnitude and often insurmountable difficulties are met. Let me, with all the power of my personality, condemn the promiscuous use of these potent and expensive endocrines. More especially as at present synthetic preparations with ten times the potency of the human products are at the disposal of the profession. It will not be until an easy and effective test has been elaborated to determine the quantity of these ingredients in the tissues, blood and urine that they will be used intelligently and scientifically. Our present means of administration are faulty and often harmful. The cases that presently lend themselves to intelligent handling are those in whom a history of previous regular menstruation can be elicited and from this, through the period of amenorrhea or metrorrhagia, a calculation can be deduced to know that estrin is being used when estrin is being elaborated in the body and progestin when the corpus is developing and active. Otherwise treatment may be absolutely the opposite of what one may desire to accomplish, and may have the effect of sinking her organs deeper in the fog of their endocrine environment. Of course, the cases where such a fortunate calculation can be made are relatively rare. In the vast majority of cases, intelligent exhibition of estrin and progestin can be hoped for only after laboratory estimates of the urine content can establish the curve of secretion. Thus, and thus only, can we hope for consistent results. When this is possible, the results in cases of temporary aberration of ovarian function are brilliant. But here again we must emphasize the difference in the outlook in cases of exhaustion and of fatigue—the temporary improvement, but ultimate futility of treatment in exhaustion, and the effective results, and often permanency in cases of fatigue. The work of Browne and others has shown how deficiency in prolan causes a marked fall in progestin, and this in turn may be the intimate cause of quantitative diminution in menstrual flow and sterility, and, what is more important, may be the cause of threatened and inevitable abortion. The administration of prolan in habitual abortion of this type, by computation of pregnandiol in the urine, has proved its scientific correctness and its practical worth. A sudden drop in prolan during pregnancy is tantamount to a threatened abortion. Unfortunately, one cannot tell when the treatment will prove futile or not, for one cannot tell how much damage to the pregnancy may have resulted from the initial fall in prolan secretion. The relationship between ovary and thyroid is better understood than some of the others. We do know that in cases of hyperthyroidism, diminished menstrual flow or complete amenorrhea is the rule, and, per contra, hypothyroidism is commonly followed by menorrhagia and metrorrhagia, and the correction of either of these two thyroid derangements promptly brings about a return to normal in the pelvic cycle. The rôle of athyrea or diminished thyroid output in sterility is also well known, and the

practical application of thyroid therapy under these circumstances constitutes one of the brilliant pages in endocrine research. How the dyscrasia operates in bringing about sterility and how the therapy corrects it, are questions to which, as yet, an adequate answer cannot be found.

In the relationship of thyroid and ovary and pituitary, we know that the pituitary contains a thyrotropic element, and a gonadotropic element, and that the symptomatology in any pelvic disturbance may be primarily ovarian or may be primarily thyroid, with secondary ovarian symptoms, or may be primarily pituitary with secondary thyroid and tertiary ovarian manifestations; or again, it may be primarily pituitary with coincidental thyroid and ovarian dystrophies. So you readily see how complex is this subject. In a goodly percentage of cases one can see the sequence of events in the history and in the bodily structure of the patients. But these are the cases of major defects, the least amenable to treatment, and we must await the day until science and experimentation have placed at our disposal means of easy diagnosis and differentiation, to recognize these departures at their inception. In this way, and in this way only, can we hope to retard the effects of exhaustion, and to restore normalcy in cases of temporary overwork. But let us not lose sight of the fact that endocrinology, in the rapidity of its scientific development, in the mysticism of its maze of entanglement, and in its prospective potentialities, has blinded us to all other non-specific forms of treatment. We have almost forgotten that sunshine, both in the soul and in the body, a change in physical environment, a restoration of moral values, a dietetic balance, and a general heightening of all the values which collectively we recognize as health, may be much more effective means for the restoration of normalcy than the administration of fleeting endocrines without the necessary knowledge that we are using them intelligently. Even if one can use these intelligently in any given case, there is all the greater reason why such an intelligent practitioner should call to his aid the other adjuvants that are at his disposal.

Philosophy of Endocrinology

May I trespass upon your time to touch upon a subject that is dear to my heart? I refer to the philosophy of endocrinology. Just a few short abstracts from my book upon philosophy that is approaching completion. I wish to sketch the influence of endocrinology upon character. Human character is made up of individuality and personality. My individuality is what I really am. My personality is what other people think I am. My ego is what I think I am. Individuality is the product and discipline of experience, using experience in its broadest sense, meaning extrinsic and intrinsic in origin. Individuality is receptive, is the product of reception and perception. Personality is expressive, is the reaction which we create upon those within the orb of our influence. Personality is often misquoted as the spirit of a person.

Our double nervous system can be reduced to but a short double statement. Our cerebrospinal system gives us our orientation in the universe; the autonomic system gives each organ its orientation in its universe economy, which is the body economy.

The receptivity of the body to any experience or impression and its perception and its reaction depend upon the state of the individual at the moment of reception, and the state of the individual at any one moment is the result of the accumulated experiences of all the previous moments, back to the beginning of evolution. Chief among the factors which determine the acuteness or dullness of receptivity, and equally the powers of perception and the type of reaction which these predetermine, are the endocrines. The endoctrines predetermine the personal character of emotions and, in turn, are highly influenced by the emotions. So that to teach a child emotional control gives it a double advantage. Heredity gives us our texture, which predetermines the capacity for absorption and expression, and behind texture again are the endocrines. May I just interpose here the vast difference upon the individual between a normal thyroid activity—the excessive reaction of the hyperthyroid and the dull reception and perception and reaction of the individual afflicted with hypothyroidism? So that, in the last analysis, individuality and personality is intimately bound up with endocrinology in preparing the soil and thereby both the impression and expression, which mean character.

Relation to Mental Reactions

The law of causality is operative equally in the mental as in the physical. And as such, in every animal reaction the constant is the cause, the variable is the individual, and the resultant, therefore, must be variable. This sounds like the advocacy of predeterminism as against free-will. Actually that is not so. Free-will and predeterminism are merely terms that have never had an exact definition. May I take a few minutes to make clear the disputed subject. We must begin by defining our terms. If we mean by free-will the capacity of the human mind to change the course of conduct without cause or agency, but merely as a whim, then certainly humanity has not the *curse* of free-will. But if we mean by free-will the capacity to change one's mind under the impulse of a causative agent, recognized or unrecognized, then in this sense do we truly possess the *boon* of free-will. But changing one's mind under an impulse depends upon the individual at that moment. But individuality changes at every moment, and this very individual of the moment is the product of all his ancestors and of all his impressions, both conscious and unconscious, up to and into the moment of reception and predetermines the effect of the reception, that is, perception and expression. Then this is predeterminism. True. But no one but the Omniscient could determine what would be one's reaction at that moment. If we mean by predeterminism that our actions are writ in the book of fate, naturally we would answer that this is nonsense, but if we mean by predeterminism that each change of mind is predetermined by what has gone before, then freely do I believe that actions are predetermined. Who can tell what my reaction will be at any given moment, or that it will be the same at different moments? Naturally, no one, except one who knows all the antecedents. Free-will presupposes in the minds of most people change without cause. But the law of causality is universal and operates equally in the spiritual and physical world. Science is based upon the invariability and universality of that law. So in the last analysis, the ego changes in response to external physical influences or to internal metabolic changes. Here is where the endocrines enter to exercise their influence in changes in individuality and personality. The extent of emotional responses to external stimuli depends largely upon the tempo of life in the individual at the moment of reception, and conversely the reception of stimuli and perception of their import depend upon the emotional equilibrium or imbalance at the moment of reception. So that the determination of the response in the last degree depends upon metabolism, and metabolism is one form of expression of endocrine control. In one sense we have free-will; in another, our responses are predetermined. Theoretically, it is a matter of definition; practically, it is a matter of extrinsic and intrinsic causes, operating upon a variable. That variable, the individual, is variable chiefly owing to his changing biochemistry, and biochemistry is regulated by the endocrines.

To conclude, may I add that diseases do not arise out of one causal agent, but from a series of successive causes in which, if we work back from symptoms, we find effects become causes until we go back to basic vital causes. Some schools teach merely the recognition and treatment of symptoms. Others inquire into immediate causes and endeavor to treat them; others again probe more deeply into remoter causative factors. There is a danger seldom recognized, in this deeper analysis. One is apt to get the idea that the remotest cause is the potent one, and that this must be remedied to effect an improvemen in the patient's condition; and as most of these deeper causes are irremediable, one is apt to flounder in inactive mysticism, whereas, another, less profound, will succeed to his advantage.

Nature usually asks of us that we but change the environment and she will do the rest. Sunshine on the body and sunshine in the soul will often effect the seemingly impossible in such cases. Let us remember that supplemental endocrine treatment is merely supplemental, and at most palliative, and that environmental changes may often produce better and more lasting results. Dr. Samuel Johnson, one of the world's greatest thinkers, once wrote, "It matters little how a man dies, but it matters much how he lives." That is, how his character is formed. In a work on tumors written seven years ago for a large system, I wrote the following sentence: "The incipient stages of all diseases that lead on to corporeal death (except traumatic death)

find their incipient causative agents in the early stages of glandular dyscrasies." Experience seems to confirm that dictum.

By a slow deterioration of our endocrines, metabolic control is lost, and consciousness is gradually dulled by the accumulated products of the body's own elaboration, and the Fates idly cut the string that binds our spirit to this earth, and we glide down the last declivity, happily indifferent to both our fate and our destination.

Schizophrenia

Neurological Signs*

By Wilbur A. Muehlig, M.D.

Ann Arbor, Michigan

WILBUR A. MUEHLIG, M.D.

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■ A GROUP of 500 cases of schizophrenia is being studied at the Neuropsychiatric Institute of the University of Michigan, Ann Arbor. This paper consists of a report on a small portion of this work. Sixty-five of the 500 cases were chosen because of the presence of some neurological sign or signs in each of them, and an attempt was made to correlate and interpret these neurological findings. This group does not include all of the cases out of the 500 which showed neurological signs, and therefore the statistical incidence of such signs in schizophrenia is not shown.

Review of Literature

In the literature of the past ten years there have been a number of contributions on neurological signs in schizophrenia, although they have been essentially non-significant except in a negative way. The characteristic neurological findings in catatonic schizophrenia are well known, i.e., muscular rigidity, mask-like facies, catalepsy, stiff awkward gait, non-withdrawal from painful stimuli, and so forth. The association with negativism, stereotypy, bizarre movements, excitement and other mental symptoms makes the neurological significance of this picture questionable.[5] In addition to these findings in schizophrenia, various coincidental neurological conditions have been observed, such as facial paralysis, Friedreich's ataxia, progressive muscular dystrophy, encephalitis lethargica, epilepsy, brain tumors, amyotrophic lateral sclerosis and Huntington's chorea. No significant correlation between these diseases and schizophrenia has been discovered, however. A great variety of more or less isolated neurological signs have also been observed in cases of schizophrenia. The most common of these are pupillary disorders. These were studied by Schilder and Parker[8] and were found to be most frequent in catatonic schizophrenia and more frequent in negro schizophrenics than in whites. They concluded that a constitutional factor was present, plus psychic factors, and possibly also an organic factor, such as a toxic influence or actual lesion. Runeberg[7] found pupillary abnormalities to be present in 73 per cent of a series of 100 cases of schizophrenia.

In a study made by J. M. Dorsey and L. E. Travis[4] the reflex conduction rate in five cases of stuporous catatonic schizophrenia was found to be greatly increased over that of the normal subject. This was considered to be due to a reduction in the activity of the higher motor centers.

Von Angyal[9] reported a case in which there was evidence of parietal lobe pathology, i.e., a so-called interparietal syndrome. From the description, however, the case did not seem to be a typical schizophrenia. The syndrome was characterized by disturbances of the body schema, metamorphopsia, derangement of visual elements in space, abnormalities of posture-holding and induced spontaneous movements. He states in his discussion that a few similar cases have been reported.

In addition to the above, other isolated instances of neurological signs occurring in schizophrenia have been reported, such as attacks of vertigo, cerebellar signs, paralyses, speech disturbances, extra-pyramidal signs and catatonic contractures. Autonomic nervous system disorders are, of course, rather common, as shown by dermographia, and cyanosis and edema of the extremities. The obvious circulatory changes

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have been frequently observed and written about. Some of the other disturbances require special technic and study to demonstrate.

There are also some studies reported which have yielded negative results.[1,2,3,6] W. Bromberg[3] studied the perception of tactile after-effects in schizophrenics and normals and concluded that there are no changes in the perceptive field in schizophrenia.

Five Hundred Cases

The following is part of the statistical study being made on 500 cases of schizophrenia at the University of Michigan. In this paper the study has not been made on all 500 of these cases but is confined to sixty-five cases, all showing neurological signs and chosen because of this. Vasomotor disturbances other than dermographia were not included. The study was made from routine neurological examinations done usually at the time of admission to the State Psychopathic Hospital at Ann Arbor, Michigan (now the Neuropsychiatric Institute). No special studies are included, such as temperature control, posture tests, induced spontaneous movements, and so forth.

Relatively common findings in the chosen group were increased tendon reflexes, dermographia, nystagmus, irregular pupils, sluggish pupils, unequal pupils, tremor of the fingers, poor coördination, and tremors of the tongue. Other less common findings were generalized sensory disturbances, local areas of anesthesia, local absence of tendon reflexes, protrusion of the tongue to one side, dysarthria, facial asymmetry, twitching of palpebral muscles, absent pharyngeal reflexes, tremors of the face and of local muscle groups, and absent corneal reflexes. The following signs each occurred in one case of the sixty-five: astereognosis, positive Romberg, tremors of the lower extremities, unilateral positive Oppenheim, convergence weakness, and bilateral deafness.

No finding was present in one type of schizophrenia more than the others to a significant degree for the number of cases studied.

Irregular pupils were found in sixteen out of the sixty-five cases studied, sluggish pupils in twelve of the sixty-five, and unequal pupils in seven of the sixty-five. These findings tend to confirm the literature. It is likely that this is part of the general disturbance of the sympathetic nervous system known to be present in schizophrenia.

Nystagmus occurred in seven of the sixty-five. It is of questionable significance, since it can be caused by various sedatives commonly used in psychiatric patients, and, of course, is occasionally found in individuals otherwise apparently normal.

Dermographia occurred to a degree considered to be abnormal in twenty-two cases of the sixty-five. This is in keeping with the vasomotor changes commonly reported in the literature. It was distributed among the types of schizophrenia approximately equally.

Attention should be called to the fact that the above figures do not indicate the incidence of the various findings in schizophrenia as a whole because of the selection of cases which was made.

In no case was there a significant grouping of neurological signs which would allow any conclusions to be drawn regarding focal lesions or a diffuse involvement of the brain. The type of signs which are found are for the most part nonspecific and often seen in apparently normal individuals. Some of the isolated signs reported are likely due to coincidental disease or secondary complications. The pupillary disturbances, which are quite common, are interesting, but no significant conclusions can be drawn from this fact other than that it is likely part of the general disturbance of the sympathetic nervous system known to be present in this disease. The same may be said of dermographia.

Summary

The literature was reviewed on neurological findings in schizophrenia and a study of this subject made on sixty-five cases of schizophrenia chosen because of the presence of some neurological sign or signs in each of them.

Conclusions

Various isolated neurological signs are found in schizophrenia, the most frequent and possibly the most significant being pupillary irregularities, dermographia, and poor coördination. No conclusions can be reached regarding localization or type of malfunctioning areas which might be present in the brain, other than that some of the signs are apparently on the basis of the general

(Continued on Page 142)

Postgraduate Courses For 1940

Short, intensive postgraduate courses will be given in the following subjects in Detroit or Ann Arbor during 1940:

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Nutritional and Endocrine Problems
Ophthalmology and Otolaryngology
Pathology
Pediatrics
Proctology
Roentgenology
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Mt. Clemens
Saginaw
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The announcement of courses will be available shortly and will be sent upon request.

Department of Postgraduate Medicine
University Hospital
Ann Arbor, Michigan

EDITORIAL

Paul de Kruif Compliments the Michigan State Medical Society

■ IN A SERIES of articles in the November, December and January numbers of *The Country Gentleman,* under the title, "The People Demand Public Health," Paul de Kruif, the leading American writer for the people on problems relating to their physical welfare, discusses the problem of raising the level of health in the United States without sacrificing the gains which we have already made. In the last of these illuminating articles he devotes a considerable portion to the Michigan State Medical Society and its voluntary health insurance plan. We quote:

"The doctors of the Michigan State Medical Society believe that they have found the answer. For nine years this progressive and public-spirited organization of physicians has been growing more and more impatient with the tragedy of Michigan's millions sick without money to buy medical care, and with the injustice to the doctors themselves doing a good third of their work for no pay. For nine years the Michigan State Medical Society has had its experts studying every known plan for health insurance, compulsory as well as voluntary.

"Now they have taken action. For adequate medical care of all of Michigan's people in low-income brackets —if they want that care—Michigan's doctors have organized a voluntary nonprofit corporation, Michigan Medical Service. Every licensed physician in the state can belong to it. State law has been passed, enabling it. A board of directors composed of physicians and laymen administers it. The State Insurance Department supervises it. What will it do for Michigan's sick people?

"Families with incomes of $2,500 and under, or individuals with a maximum income of $2,000, organizing themselves into groups of not less than twenty-five people, can obtain medical care from doctors of their own choice. The maximum yearly payment, for a family, for this service is $54. The employer can contribute part of the cost to help employees obtain benefits of this plan. This entitles them to home and office medical care and hospital visits—to an extent of $875. And the hospitals of the state have also organized a group service for care at a yearly cost of $24 per family.

"What of the masses of Michigan's people without the necessary $78 per family per year for medical and hospital care? Michigan Medical Service has organized a medical relief division. For those who are destitute or in the very low income group—the medically indigent—arrangements may be made with governmental agencies to pay all or part of the subscription cost. This is specifically provided for in the law. These medically indigent, too, will have medical care from doctors of their own choice.

"What, then, would be the Federal Government's part in aiding the doctors of states organizing such group medical service for all citizens who can't pay adequate medical service individually? Under a national health law, the Federal health authority could make direct grants in aid to such states as cannot by themselves bear the total cost of the state-wide medical care of their people in those income brackets where sickness may at any time mean financial disaster.

"Each state's medical needs are different. But the Michigan medical-care plan can be made flexible enough to fit the needs of any American locality. At the same time, every state must cut and try in the business of what income brackets should be included, what fees are fair to the doctors, what subscription rates for medical service can be borne by the people.

"A national health law encouraging compulsory health insurance in any state would antagonize not only that state's but the nation's doctors. But if the national health law will explicitly encourage every state's doctors to do as Michigan's doctors have done—to work out their own medical-care system—the doctors can and will go on giving medical care while the bookkeeping details are being worked out."

Industrial Health Problems

■ IT WAS POINTED OUT in the January JOURNAL that about 90 per cent of the health problems of the industrial workers are not industrial in nature, and that about 65 per cent of all employed people are treated by general practitioners for occupational injuries and diseases, as well as all other sickness and injuries. So it is evident that the health of the workers is predominantly in the hands of general practitioners. In view of this, and because of rapidly increasing interest on the part of industrial management in the health of the workers, it is clear that here is a job for the medical profession.

Disease Prevention

Industry particularly wishes measures for disease prevention. True enough, the official public health agencies have their disease prevention

programs and their industrial hygiene activities, however, there is much (for which industry expects to pay) over and above these that can be done in industry by general practitioners. These include pre-employment and periodic health examinations, and advice to management on the control of real and possible sources of disease in their plants. To do these properly, some knowledge of industrial conditions is necessary.

You Can Help

No doubt many of you treat patients from industry even though you do not regard yourself as industrial physicians. When you discharge these for light work or usual work, do you know enough about their jobs to justify your recommendations? When you return patients to industry with unpreventable physical handicaps, how far can you go in assisting in their rehabilitation? When you suspect an occupational disease, do you know that the exposure claimed is an adequate cause of that disease? If you have no direct contacts with industry, can you understandingly coöperate with industrial physicians in their case finding programs in order that the workmen may derive maximum benefits? And are you informed on means of coöperating with official health agencies in the handling of the health problems of the employed population? All of these are questions which are coming to the front in this great industrial State, and the Michigan State Medical Society is preparing to meet them through the Committee on Industrial Health.

The Afflicted-Crippled Child

■ Requests, from several County Societies that The Council present a guiding statement for our members in the handling of the unfortunate children requiring state aid in treatment of their afflictions, have been admirably satisfied by the statement sent out to each member as a secretary's letter and also printed below.

Certain politicians seem desirous of making a political football of the care of these children. The first "economy" move consisted of the announced intention of hiring a business administrator and six medical coördinators, meaning an additional expense of more than thirty thousand dollars. (Each county now has a Social Welfare Commission which has machinery for investigating the economic status of applicants for state aid.) This amount would provide medical or surgical expense of twelve hundred children for a year or complete care for two hundred crippled or afflicted children.

The statement of principles, as prepared by The Council, is clear and definite. Following this chart of procedure will achieve the most toward a humanitarian, unpolitical and intelligent handling of these future citizens of the state.

Statement of The Council

Four factors enter into the problem of the afflicted and crippled child, viz.:

(a) Statutes providing state-aid
(b) Inadequate appropriations
(c) An unpredictable commodity (sickness)
(d) An established fee-schedule

The Statutes were revised in 1939 and gave the Crippled Children Commission more power in the control of commitments, but failed to provide funds for the employment of coördinators.

In the words of Governor Dickinson, the appropriations were too drastically cut.

Sickness being an unpredictable commodity, deficits in appropriations may occur.

The determination of the case-load is not the great problem, but the determination of what proportion of the case-load is the responsibility of the State and what part is the responsibility of the family, is the problem—in other words, the problem is one of efficient economic filtering.

In 1933 fee schedules A and C were established in conference of the Crippled Children Commission and the MSMS and were based on costs to the physician of rendering the services. Any reduction in these schedules is demanding a service at less than its cost of production. This is not done by the State in the purchase of any other commodity or service.

Any other group would refuse to render service or supply commodities on such a basis; but in the interests of public safety, physicians, as a group, cannot "strike."

The physicians of Michigan recognize only one quality of medical care—the best; and the children of Michigan, irrespective of their economic status, are entitled to this quality of medical and surgical care.

Due to the nature of medical and surgical services, no lay organization can set equitable fees for such services without consultation with the medical profession.

Should schedules A and C be reëstablished the doctors of the State of Michigan might well adopt the plan of coöperating with the State of Michigan and the Crippled Children Commission by reëstablishing the Medical Filter Board in all counties of the State—these boards to pass on medical and surgical need and urgency—providing the Crippled Children Commission will enforce the Economic Filter, free from political intrigue.

In the event that Schedules A and C are not re-established by the C.C.C., rather than accept ridiculously low fees, the physicians of Michigan might well return to their traditional right of rendering charity to the individual (not the State) whom they personally determine so deserving.

This imposition on the medical profession may persist until such a time as we have a change in the policy of the state administration or the time when it can be made a legislative issue in which the laborer is considered worthy of his hire.

Keeping Records

■ MANY of the recent attacks made upon the medical profession have brought out the fact that most doctors do not know "what it costs them to do business." We have always maintained, as a group, that our costs amounted to about fifty per cent of the gross income. However, some doctors do not believe that to be true and claim they can make a profit taking care of relief clients. There are a number of factors which they do not consider. Among them:

The average doctor is able to practice actively less than twenty years.

When disability of the doctor occurs, his income ceases entirely.

He is dealing with a very fragile and perishable commodity; one error of judgment may be the termination of his ability to attract enough patients to make a living.

When he passes from this earth about the only thing he leaves his family, from his business, is uncollectable accounts.

Much of his personal expense, while not deductible in computing income tax payment, is directly responsible to his business.

The Charity You Forget

The doctors donate more to charity than any other group of people but since it is not donated to organized charity he cannot deduct it from his income tax report and the donation is not taken into account by those who solicit him for contributions. This is partly so because the average doctor does not know how much charity he does, which brings us to the matter of keeping records.

Why Not Know

Any public accountant knows that every item of business should be made a matter of record, a charge made, and then when indicated, charged off to charity. When this is done, together with the usual bookkeeping system, it is easy to know how much it costs to make a call at the house; how much it costs, per mile, to go out into the country; and how much it costs to see a patient in the office. There are probably very few doctors in Michigan who can see a patient in the office for seventy-five cents, and not lose money; and there are still fewer doctors who can make house calls for a dollar and a half, and not lose financially.

Preventive Medicine Records

There is a determined effort on the part of some public health officials to take away from the practitioner the field of preventive medicine. The most difficult argument to refute is that the general physician does not keep records and consequently there is no way of determining who and how many are protected from preventable disease. Keeping an accurate account of the preventive measures performed will pay big dividends to the profession in the end. If you keep good records, the records will keep you.

Haste Is Necessary

■ THE MICHIGAN SOCIETY for Group Hospitalization is making an exception in its plans to only accept applicants in groups of ten or more and will accept individual physicians under their plan. This move indicates the coöperative attitude of the M.S.G.H. and it is hardly necessary to advise each member to take advantage of this offer.

The application must be received by them by February 15. So, do not delay.

Welcome, North Carolina Medical Journal

■ THE JOURNAL of the Michigan State Medical Society congratulates the Medical Society of the State of North Carolina on its newly established *Journal.* Its editor, Wingate M. Johnson, has long been known as a medical writer and the first number indicates that the new journal will take its place among the leading medical publications of the United States. Our best wishes to Dr. Johnson and assurance of complete coöperation of our staff.

Re-elected

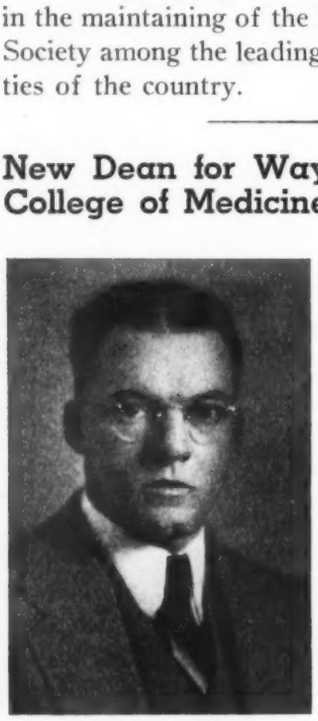
■ THE COUNCIL at its annual meeting expressed their appreciation of the invaluable service given by Dr. Foster, Dr. Hyland and Mr. Burns, by continuing them in their respective positions of Secretary, Treasurer, and Executive Secretary. Their unusual innate ability in their fields of service and the unstinted time and labor they have so willingly given is one of the chief factors in the maintaining of the Michigan State Medical Society among the leading progressive state societies of the country.

L. FERNALD FOSTER, M.D.

WM. J. BURNS, LL.B.

WM. A. HYLAND. M.D.

New Dean for Wayne University College of Medicine



EDGAR H. NORRIS, M.D.

■ EDGAR H. NORRIS, M.D., was appointed Dean of Wayne University College of Medicine, December 12, 1939. He had been head of the Department of Pathology since December, 1938. Dr. Norris was born October 19, 1893, at La-Grange, Indiana. He received his formal education at the University of Minnesota, from which he obtained the degrees: B.S., 1915; M.A., 1916, M.D., 1919. Upon graduation he was instructor in anatomy and pathology at his Alma Mater for three years and then did graduate work in embryology at Johns Hopkins University. After interning at Minneapolis General Hospital, he became an associate of Dr. Arnold Schwyzer of Saint Paul, Minnesota. Following a period of illness he decided to enter the field of teaching and became a graduate student in the Department of Pathology of the University of Minnesota. He was made head of the Department of Pathology at Wayne University College of Medicine in 1938 and in this capacity he has been very successful in developing the elective courses in the postgraduate level. Under his administration of the department the first Fellowship in Cancer was established at Wayne University College of Medicine by the National Advisory Council.

The new dean understands the problems of the private practitioner. He is actively interested in postgraduate education and stands solidly with the Continuation School of Medicine of the Wayne County Medical Society.

WILFRID HAUGHEY, M.D., Battle Creek
Chosen Chairman of the Publication Committee for 1940.

New Councilors

O. O. Beck, M.D.

R. S. Morrish, M.D.

O. O. Beck, M.D., was born in Grand Island, Nebraska and after pre-medical studies at Central Wesleyan College, and pre-clinical medical work at Missouri University, he received the degree of Doctor of Medicine at Northwestern University Medical School in 1920. He interned at Harper Hospital at Detroit and subsequently spent seven months with the American Relief Administration in Russia as Medical Director of the Orenburg District, during the famine in 1922. He then practiced medicine for a short time in Detroit, and in the summer of 1923 began practice in Birmingham. He has been secretary of the Oakland County Medical Society for the past three years and was chairman at the recent Secretaries' Conference held in Lansing. He was appointed councilor of the Fifteenth District on January 15, 1940, to fill the unexpired term of George A. Sherman, resigned.

R. S. Morrish, M.D., a native son of Flint, was raised on a farm and received his degree from the University of Michigan Medical School in 1912. After a brief period of practice in Lorain, Ohio, he entered general practice in Flint, but limited his practice to surgery in 1920. He has served in various capacities in his county society and was a member of the first Committee on Maternal Health of the Michigan State Medical Society. He has been on the staff at Hurley Hospital, Flint, since 1912 and has been Director of General Surgery since 1931. He is also on the staff at St. Joseph's Hospital. He is chairman of the Genesee County Chapter of the American Red Cross, and was Director of the Genesee Area U. S. Veterans' Administration from 1919 to 1938. He retired from the Army in 1919 after two years of service with the rank of Major. He was appointed councilor of the Sixth District on January 15, 1940, to fill the unexpired term of I. W. Greene, resigned.

Do Not Forget Your Postgraduate Program for 1940

"A few physicians increase in knowledge from within and grow from their own doing. These are the innate investigators. The rank and file require outside help to grow and to progress. Books, meetings, contacts, discussions, teachers, are our armamentarium for progress. Like the 'spring tonic' of past days, all of us need some of this medicine at least annually, better if it comes more frequently. A large majority of physicians know their need and seek treatment."—Henry A. Christian, M.D.

YOU AND YOUR BUSINESS

OBJECTIVES AND ACTIVITIES OF M.S.M.S.

Sociologic

The Michigan State Medical Society and its component county societies bring you these valuable benefits of membership:

1. Accords position of social responsibility in the community—the trust and opportunity of the medical profession to assume leadership in all medical matters.
2. Continual development and maintenance of confidence in the medical profession—in *you* —by a constant alert program of public relations by your state society.
3. Your medical society acts as sales ambassador of the medical profession in your community.
4. Results from unified action to solve problems of distribution of medical care to all groups in the state.
5. Unites you with those who strive to maintain what you know is best for your patients and yourself.
6. Authentic information to an inquiring public regarding good medical service and the standing of practitioners.

You cannot afford to be outside the Society. Your destiny is intimately related to the success of your county, state and national medical organizations.

CONSENT OF PARENT OR GUARDIAN

The general rule is that the physician has no legal right to render professional services to a minor without the specific or implied consent of his parent or guardian, excepting in emergencies and then for the sole purpose of saving life. . . . Since public health nurses, school nurses, and social workers nowadays take minors almost promiscuously into institutions and to private physicians for various purposes without having been safeguarded by the proper consent from the parents, physicians are taking great chances in courting malpractice actions in attending such cases. Of course, so long as everything goes well and the minor claims no injury, well and good; but let the minor seemingly be injured, then adverse litigation involving the physician is most apt to follow.

Medical Jurisprudence, by Carl Scheffel, Ph.B., M.D., LL.B. P. Blakiston's Son & Co., 1931.

OCCUPATIONAL DISEASE REPORTING LAW

In 1911, the Michigan Legislature placed on the statute books an occupational disease reporting law (Act No. 119 of the Public Acts of 1911—Section 8613).

This Act provides that every physician, hospital superintendent or clinic registrar having knowledge of a case of occupational disease shall, within ten days, report same to the State Department of Health on forms provided by that Department, giving the name and address of the patient, name and business address of the employer, the business of the employer, the place of the patient's employment, the length of time of his employment in the place where he became ill, the nature of the disease, and any other information required by the State Department of Health. These reports are declared by law *not to be public records.*

The State Health Commissioner is authorized to provide suitable blanks for reporting occupational diseases, and instructions for their use, and to furnish them freely to registered physicians, medical clinics, hospitals and industrial plants. He is also authorized to publish periodically statistical summaries of all occupational diseases reported.

Failure to make these reports required by the law is deemed a misdemeanor.

NATIONAL CONFERENCE ON MEDICAL SERVICE

The National Conference (formerly the Northwest Regional Conference) will hold its fourteenth annual meeting at the Palmer House, Chicago, on Sunday, February 11, 1940. All

state medical societies have been invited to send representatives to the Conference, designed to provide a medium for the verbal exchange of information on progressive medical service activities being conducted throughout the United States, and to discuss the solution of problems arising from the distribution of medical service to all classes. The Conference affords an opportunity for physicians officially associated with or personally interested in medical economics to exchange ideas for the good of the profession and the public.

The 1940 program was designed to give sound practical information on problems and programs facing the profession, individually and as a group.

Program

Registration—9:30 a. m.

MORNING SESSION—10:00 a. m.

I. Group Medical Care and Group Hospitalization Programs
   1. Missouri's Program (10 min.).....
      C. F. VOHS, M.D., St. Louis, Mo.
   2. Experiences of Associated Hospital Service Plan of New York (10 min.).....
      DAVID H. MCA. PYLE, New York City
   3. Michigan Medical Service (10 min.).....
      HENRY R. CARSTENS, M.D., Detroit

   Q and A Period (30 min.)
   Leader: R. L. SENSENICH, M.D., South Bend, Ind.

II. Allocation of Federal Funds to States (20 min.) .....R. G. LELAND, M.D., Chicago

   Q and A Period (15 min.).
   Leader: WM. F. BRAASCH, M.D., Rochester, Minn.

III. Recent Developments on the National Scene..
      E. H. CARY, M.D., Dallas, Texas

LUNCHEON SESSION—12:00 M.

IV. Business Meeting
   1. Report of the year. Election of Officer. Selection of place and time of 1941 meeting.
   2. Address (30 min.).....
      PAUL G. HOFFMAN, South Bend, Ind.
      President, The Studebaker Corporation

AFTERNOON SESSION—2:15 p. m.

V. Effective Public Relations (20 min.).....
      E. J. MCCORMICK, M.D., Toledo

   Discussion (10 min.).....
      MORRIS FISHBEIN, M.D., Chicago

VI. Medical Welfare Programs:
   1. Farm Security Administration (10 min.)...
      R. C. WILLIAMS, M.D., Washington, D. C.
   2. Outdoor Indigent Care (10 min.).....
      HILTON S. READ, M.D., Atlantic City, N. J.
   3. Medical Relief in Chicago (10 min.).....
      C. H. PHIFER, M.D., Chicago
   4. Medical Surveys (10 min.).....
      CREIGHTON BARKER, M.D., New Haven, Conn.

   Q and A Period (30 min.)
   Leader: ERNEST E. SHAW, M.D., Indianola, Iowa

L. Fernald Foster, M.D., Bay City, President of the National Conference, invites all members of the Michigan State Medical Society to attend the National Conference on Medical Service meeting in Chicago.

ROY HERBERT HOLMES CHOSEN EDITOR

Roy Herbert Holmes, M.D., of Muskegon, was elected by The Council at its Mid-winter Meeting of January 13-14, 1940, as editor of THE JOURNAL of the Michigan State Medical Society.

ROY HERBERT HOLMES, M.D.

Dr. Holmes assumes the mantle of James H. Dempster, M.D., who for the past twelve years has been editor of THE JOURNAL and who resigned as of December 31, 1939. The Council paid tribute to Dr. Dempster and presented him with a scroll in recognition of his long service to the Society and to Medicine.

The new Editor has had a decade of experience to qualify him for his new work. During six of these years he was editor of the *Muskegon County Medical Bulletin.* A Who's Who account of Dr. Holmes was published in the December JOURNAL.

Congratulations, Dr. Editor, and best wishes for full success and enjoyment in your new position!

Has your County Medical Society held a "State Society Night" to learn from your State Officers what problems are facing you and Medicine?

MID-WINTER MEETING OF THE COUNCIL, M.S.M.S.
January 13-14, 1940

FIRST SESSION

1. *Roll Call.*—The meeting was called to order by Chairman Henry R. Carstens, M.D., in the Judge Woodward Room, Statler Hotel, Detroit, at 10:25 a.m., with all Councilors and officers in attendance. Also present were State Health Commissioner H. A. Moyer, Deputy Commissioner Carleton Dean, Drs. J. H. Dempster and J. J. O'Meara, and Executive Secretary Wm. J. Burns.

2. *Introduction of New Councilor.*—Chairman Carstens introduced to The Council, Dr. R. J. Hubbell of Kalamazoo, Councilor of the Fourth District.

3. *Minutes.*—The minutes of the meeting of the Executive Committee of The Council, December 15, 1939, were approved as read.

4. *Appointment of New Councilors.*—President Corbus presented nominations to fill the positions of Councilor left vacant by the resignations of I. W. Greene, M.D., of the 6th District, and G. A. Sherman, M.D., of the 15th District. President Corbus presented the name of Ray Morrish, M.D., Flint, as Councilor for the 6th District; and O. O. Beck, M.D., of Birmingham as councilor for the 15th District, to fill the respective unexpired terms. Motion of Drs. DeGurse-Miller that the appointment of Drs. Morrish and Beck be confirmed. Carried unanimously.

5. *Secretary's Annual Report* was read by Dr. Foster, as follows:

SECRETARY'S ANNUAL REPORT

I herewith submit the report of the Secretary for the year 1939.

The activities of the year just ended placed great demands of time and effort on the Society's administrative personnel, and most especially upon the Executive Committee of its Council. These were occasioned by executing the usual projects of the Society and the added duties of developing, for operation, Michigan Medical Service.

Membership

The total paid membership for 1939 was 4,383 (plus 42 Emeritus and Honorary Members), with net dues of $45,078.25 accruing to the society. The number of physicians with unpaid dues at the end of 1939 was 73. The membership tabulation for the years of 1938 and 1939 showing net gains and losses, unpaid dues and deaths is as follows:

1938	1939	Gain	Unpaid	Deaths
4,205	4,383	178	73	63

With an estimated 4,700 potential members of the Michigan State Medical Society, the present membership of 4,425 would indicate 275 eligible non-members in the State. With a steady increase in the membership during the past three years (over 800), it is very evident that the society is rapidly approaching the time when only a slight increase can be expected.

MEMBERSHIP RECORD

County	1938	1939	Loss	Gain	Unpaid	Deaths
Allegan	24	23	1	–	1	–
Alpena-Alcona-Presque Isle	18	20	–	2	–	–
Barry	14	14	1	–	–	–
Bay-Arenac-Iosco-Gladwin	74	77	–	3	–	1
Berrien	62	68	–	6	4	1
Branch	23	24	–	1	–	1
Calhoun	118	117	1	–	2	1
Cass	15	13	2	–	–	1
Chippewa-Mackinac	23	23	–	–	1	–
Clinton	10	11	–	1	–	–
Delta-Schoolcraft	30	29	1	–	1	–
Dickinson-Iron	24	19	5	–	1	1
Eaton	29	28	1	–	1	–
Genesee	155	163	–	8	7	2
Gogebic	26	23	3	–	1	1
Grand Traverse-Leelanau-Benzie	41	42	–	1	–	–
Gratiot-Isabella-Clare	40	36	4	–	1	1
Hillsdale	25	27	–	2	–	1
Houghton-Baraga-Keweenaw	38	42	–	4	–	1
Huron-Sanilac	26	26	–	–	1	2
Ingham	139	141	–	2	–	3
Ionia-Montcalm	40	42	–	2	–	–
Jackson	97	93	4	–	–	–
Kalamazoo*	132	118	14	–	–	2
Kent	236	234	2	–	6	4
Lapeer	14	16	–	2	–	–
Lenawee	44	44	–	–	1	2
Livingston	17	21	–	4	–	1
Luce	11	10	1	–	–	1
Macomb	38	39	–	1	–	–
Manistee	16	16	–	–	–	2
Marquette-Alger	42	40	2	–	2	1
Mason	12	9	3	–	2	2
Mecosta-Osceola	19	16	3	–	–	–
Menominee	13	14	–	1	–	–
Midland	14	15	–	1	–	–
Monroe	34	35	1	1	–	–
Muskegon	82	79	3	–	–	1
Newaygo	10	13	–	3	–	1
Northern Michigan (Antrim-Charlevois, Emmet-Cheboygan)	31	33	–	2	1	2
Oakland	123	136	–	13	1	4
Oceana	10	11	–	1	–	–
O.M.C.O.R.O. (Otsego, Crawford, Oscoda, Montgomery, Roscommon, Ogenaw)	17	23	–	6	–	–
Ontonagon	8	8	–	–	–	–
Ottawa	32	32	–	–	1	–
Saginaw	94	102	–	8	–	1
Shiawassee	32	31	1	–	–	1
St. Clair	51	55	–	4	–	1
St. Joseph	19	23	–	4	–	–
Tuscola	32	32	–	–	–	–
Van Buren	–	27	–	27	–	–
Washtenaw	162	174	–	27	–	–
Wayne	1,746	1,855	–	109	37	17
Wexford-Kalkaska-Missaukee	22	21	1	–	–	–
	4,205	4,383	53	231	73	63
		4,205		53		
		178		178		

Emeritus & Honorary Members..... 42
Paid Members 4,383
Total 4,425

Deaths During 1939

During 1939 we regretfully record the deaths of the following sixty-three members:

Bay County—J. W. Leininger, M.D., Gladwin.
Berrien County—R. B. Taber, M.D., Benton Harbor.
Branch County—W. C. Danley, M.D., Union City.
Calhoun County—Wm. H. Haughey, M.D., Battle Creek.
Cass County—S. E. Bryant, M.D., Dowagiac.
Dickinson-Iron County—Edward M. Libby, M.D., Iron River.
Genesee County—A. T. Paull, M.D.; Hugh A. Stewart, M.D., Flint.
Gogebic County—Robert I. Prout, M.D., Wakefield.
Gratiot-Isabella-Clare County—J. A. Reeder, M.D., Clare.
Hillsdale County—James A. Bates, M.D., Camden.
Houghton-Baraga-Keweenaw County—R. J. Maas, M.D., Houghton.
Huron-Sanilac County—A. J. Howell, M.D., Bay Port; J. O. Lunn, M.D., Harbor Beach.
Ingham County—O. H. Freeland, M.D., Mason; Robert E. Miller, M.D., Lansing; Samuel Osborn, M.D., Lansing.
Kalamazoo County—Ward E. Collins, M.D.; Leo J. Crum, M.D., Kalamazoo.

*Kalamazoo—1938 inc. Van Buren County

Kent County—John N. Holcomb, M.D., Hillis D. Rigterink, M.D., Edward W. Tolley, M.D., H. C. Wolfe, M.D., Grand Rapids.
Lenawee County—George H. Lamley, M.D., Blissfield; C. S. Lane, M.D., Hudson.
Livingston County—H. P. Mellus, M.D., Brighton.
Luce County—Clarence D. Hart, M.D., Newberry.
Manistee County—David A. Jamieson, M.D., Arcadia; A. A. McKay, M.D., Midland.
Marquette-Alger County—Theodore A. Felch, M.D., Ishpeming.
Mason County—G. O. Switzer, M.D., Wm. Herbert Taylor, M.D., Ludington.
Muskegon County—A. B. Egan, M.D., Muskegon.
Newaygo County—N. DeHaas, M.D., Fremont.
Northern Michigan (Antrim, Charlevoix, Emmet, Cheboygan)—John T. Craddock, M.D., Mackinac City; George W. King, M.D., Charlevoix.
Oakland County—Frank S. Bachelder, M.D., Daniel G. Castell, M.D., Pontiac; E. J. Linsday, M.D., Walled Lake; C. S. Strain, M.D., Rochester.
Saginaw County—Chester H. Sample, M.D., Saginaw.
St. Clair County—Alexander J. MacKenzie, M.D., Port Huron.
Shiawassee County—Walter E. Ward, M.D., Owosso.
Washtenaw County—Conrad George, M.D., Francis A. Scott, M.D., Ann Arbor; Thomas W. Paton, M.D., Ypsilanti.
Wayne County—C. H. Belknap, M.D., Wm. R. Clinton, M.D., Charles W. Courville, M.D., C. R. Davis, M.D., P. C. Dodenhoff, M.D., Bernhard Friedlaender, M.D., Frank Kilroy, M.D., Stephen H. Knight, M.D., George C. Kreutz, M.D., R. Lee Laird, M.D., David M. Levine, M.D., Angus McLean, M.D., Edwin D. Merritt, M.D., James I. Murray M.D., Detroit; Francis J. Grandfield, M.D., New Boston; David McClurg, M.D., Highland Park; Thaddeus Walker, M.D., Grosse Pointe.

Financial Status

The fiscal year closed December 20, 1939, and the statement of our certified accountants, Ernst & Ernst, shows the financial condition of the Society on that date. The following facts are noted:

1. The assets of the Society are listed at $43,399.91 as compared with $43,821.55 of a year ago.
2. THE JOURNAL income was $19,603.92, composed of subscriptions of members $6,439.75; other subscriptions, $82.00; advertising receipts $11,051.29; JOURNAL cuts, $263.45; and reprint sales $1,767.43. The The JOURNAL expense totaled $18,778.65, consisting of $2,800.00 for editor's salary and expense; printing and mailing $10,567.66, reprints $1,367.95, discounts and commissions on advertising $1,993.04, postage $250.00 and $1,800.00 allocation for administrative and general office expense, a net income of $825.27 (with subsidy). Add to this the $1,800.00 allocation (as was done in 1938), and our net income on THE JOURNAL (with subsidy) equals $2,625.27.
3. Dues Income was $45,078.25, an increase of $2,041.62. Interest received totaled $763.06, an increase of $54.73. Miscellaneous receipts of $84.37 brings the total income to $46,750.95. The usual expenses totaled $34,776.24, leaving $11,974.71.
4. The Medical Defense fund received no allocation of dues in 1939. $6,000.00 was assigned to Wm. A. Hyland, M.D., as trustee under bond to administer it for any medical-legal obligations of the Society incurred up to December 31, 1939; the remainder of this MSMS Defense Fund, in the amount of $1,926.23, was transferred to the general funds of the Society.
5. The Society agreed to furnish working capital of $10,000.00 to Michigan Medical Service, and have also advanced $6,760.68 additional for organization expense. This total of $6,760.68 is to be repaid to the Society when, as and if the earnings of Michigan Medical Service are sufficient.

   After withdrawal of $16,760.68 for Michigan Medical Service and elimination of the Medical Defense Fund by transfer of $6,000.00 in assets to a trustee, the net worth of the Society is $24,224.35 as compared to $26,601.84 a year ago (a decrease of $2,377.49). The assets of the Society will be increased when Michigan Medical Service shows a profit and repays the $16,760.68. The sum of $6,000.00 is considered adequate to care for any medical-legal obligations incurred to December 31, 1939, and any funds remaining will be returned to the Society.

The invested funds of the Society are in bonds of well-diversified companies and in U. S. Government Savings Bonds. They have a market value of $28,667.50, a decrease of $111.50 from a year ago.

The coming year will probably call for further advances to Michigan Medical Service which, with necessary routine operative charges, will tax the revenue of the Society to maintain its present favorable financial status.

The 1939 Annual Meeting

A record attendance for an out-of-state meeting was established at the 1939 Grand Rapids session. There was a physician-attendance of 1,250, with a total registration of 1,810. The General Assembly type of scientific program was maintained, elicited much favorable comment and attracted satisfactory attendance even through the extra day of sessions provided in the 1939 program.

The Technical Exhibits, 100 in number, received very generous attention from the registrants, and thereby maintained the established goodwill among the exhibitor group. The large number of exhibits, made possible by the available space in Grand Rapids, not only paid the entire costs of the Annual Meeting but netted a substantial profit to the Society.

For the first time in several years, space was provided for a small Scientific Exhibit. The exhibits were sponsored by institutions and organizations.

During 1939 three County Secretary Conferences were held. One in Lansing on January 15, 1939; one in Marquette for the Upper Peninsula on March 26, 1939, and one in Grand Rapids on the occasion of the Annual Meeting. The Conferences were well attended and served to correlate the various County Society activities and to desseminate much detailed information to our fifty-four component units.

Committees

Too much credit cannot be accorded to the Committees of the State Society for their activities during 1939. In addition to developing new projects and sustaining the usual programs of general medical activity, the year of 1939 presented the biennial legislative problems. These were efficiently directed by the Legislative Committee to the end that good medical legislation resulted, including the enabling act for voluntary group medical care.

Society Activities

During the past year, your two Secretaries, with members of The Council and other officers, endeavored to officially visit most of the fifty-four component county units.

It is gratifying to report that the esprit de corps of the County Societies is of the highest calibre, and there is an ever-increasing interest in the scientific and economic programs emanating from the parent organization.

During the past year MICHIGAN MEDICAL SERVICE, the Society's voluntary, non-profit group medical care plan, was developed. This development entailed a tremendous sacrifice of time and effort on the part of your administrative personnel.

A new extra-mural Postgraduate Center was authorized for establishment in Mt. Clemens. This center will function during the coming year.

Through the new State Health Commissioner, H. Allen Moyer, M.D., a very fine liaison has been developed with the Michigan Department of Health.

Governmental and press contacts have been maintained throughout the past year to the end that the best interests of the people's health might be served and the greatest possible utility made of our physicians' services.

Publicity of the State Society's activities has been made to the individual members and county societies through various bulletins and letters. During the year nineteen Secretary's Letters were published; fourteen to the county secretaries and five to the entire membership.

Sustained interest in many major activities must be maintained during the coming year—*e.g.,* the problems of the Crippled and Afflicted Child, and Medical Welfare.

Recommendations

Your Secretary concludes his report respectfully recommending that:

1. Consideration be given to the establishment of a part or full-time Press Relations contact.

2. An immediate public relations drive of information to county societies and members be instituted through *State Society Night meetings,* attended by the Councilor, the Public Relations Committee member, and such other M.S.M.S. officers as may be able to attend.

3. The transmission of information and facts on socialized medicine to the public be established by individual doctors of medicine in their offices and by re-created Speaker's Bureaus in each county society. "An informed public means a free profession."

4. Every County Society be urged to make contacts with its doctors of medicine County Social Welfare Board re arrangements for services to welfare clients and the medically indigent; and that each Society submit tentative agreements to the State Society for advice and suggestions so that generally uniform agreements may be instituted throughout the State. This recommendation is made in order that good quality medical care may be assured and equitable fee schedules established.

5. The General Session type of program at the Annual Session be maintained in 1940.

As we review the past year, it becomes more and more apparent that the location of our Executive Office, in the capital city, has been well justified. This establishment has resulted in better coöperative efforts between the Michigan State Medical Society and the various agencies of government—a liaison vital and necessary if the best interests of both the public and medical profession are to be served.

Your Secretary wishes to take this opportunity to express his appreciation to this Council for its splendid coöperation during 1939. It is a real pleasure to congratulate the officers and committees for their interest and efforts in their work. Needless to say, our Executive Secretary, Bill Burns, and his office personnel have been untiring in their efforts in the interests of organized medicine. Mr. Burns has given unstintingly of his enthusiasm, inspiration, and unique organizational ability, and for his valued aid your Secretary is truly grateful.

L. Fernald Foster, M.D.,
Secretary.

The report was referred to the County Societies Committee.

6. *Health Commissioner.*—The Chair called upon Dr. Moyer who discussed the work of the cancer field representative and stated he was going to include in the Health Department's 1940-41 budget an item for the continuation of this service. Dr. Moyer also reported that his department has been successful in obtaining the return of $20,500 from counties which had been repaid by former tuberculosis patients. This amount of money represents approximately 13,000 patient days, and can be used to treat other cases of tuberculosis.

Dr. Moyer was thanked for his attendance and information, and retired from the meeting with Dr. Dean.

7. *Treasurer's Report* was presented by Dr. Hyland as follows:

TREASURER'S ANNUAL REPORT

As treasurer of the Michigan State Medical Society, I wish to submit the following report for the year 1939.

As required by the by-laws of the Michigan State Medical Society, the usual indemnity bond was filed with the secretary of the Michigan State Medical Society.

On January 14, 1939, the $2,000 Central Illinois Public Service 4½% Bond was called at 102½.

On April 15, 1939, the $2,000 Commercial Investment Trust 3½% Bond was called at 103½.

In place of these securities the following bonds were purchased:

$1,000 Kresge Foundation 3½% Bond, due Feb., 1947
1,000 United States Savings Bonds
1,000 Union Pacific 3½% Bond, due 1970
1,000 Consolidated Oil Company 3½% Bond, due 1958

Two of the three issues which are rated as lesser-standard, namely, the Grand Rapids Affiliated Corporation and the New England Gas and Electric bonds, have enhanced in total value of $300 over a year ago. The Grand Rapids Affiliated Corporation Bonds are upon the Grand Rapids Trust Building, which building was recently purchased by the National Bank of Grand Rapids as a result of its amalgamation with the Grand Rapids Trust Company. This will naturally increase the value of these bonds as well as their rating.

The Associate Gas and Electric Bonds have been carried on our books at 25. This company has been in difficulty with the Government over the policy of the management of their large interests for some time and have been threatening to ask for receivership even though they are making money at the present time. We have had a bid out for some time to sell these bonds, but as yet there has been no offer. It is my belief that if they were to liquidate today, the bonds would liquidate at a much higher figure than 25. This bond will eventually be worth much more, when they adjust their Government matters. However, if we can get an offer for the disposal of these two bonds, namely, the Associated Gas & Electric Co., I will be very glad to present it to the Committee.

The following securities were held by the Michigan State Medical Society at the end of 1939:

	Quoted Market Price January 10, 1940
Union Pacific Railroad	$ 972.50
Consolidated Oil Corporation	1,055.00
Associated Gas and Electric Corporation	570.00
New England Gas and Electric	1,400.00
Standard Oil of New Jersey	1,052.50
United Light and Power	2,140.00
Grand Rapids Affiliated Corporation	1,500.00
Consumers Power Company	2,130.00
American Telephone & Telegraph	2,018.00
Kresge Foundation	1,052.50
United States Govt. Savings Bonds	8,800.00
Detroit Edison Company	2,212.50
New York Central Railroad	1,230.00
Govt. Dominion of Canada due 1945	963.75
Govt. Dominion of Canada due 1967	885.00
Canadian Pacific Railroad	1,225.00
Southern Pacific Railroad	1,020.00
National Gas and Electric Corporation—96 Common share	324.00
	$30,605.75

Respectfully submitted,
Wm. A. Hyland, M.D.,
Treasurer

The report was referred to the Finance Committee.

8. *Editor's report* was presented by Dr. Dempster as follows:

EDITOR'S ANNUAL REPORT

In writing this, my final report as editor, I may be excused if I become reminiscent. Up to the time I was approached thirteen years ago by Dr. J. D. Bruce, at the time chairman of the Publications Committee, I had decided to devote all my time to my practice and had no thought of editorship. In the year 1926, the Council had decided to separate the function of editor from that of secretary. Up to this time, the secretary of the society bore the hyphenated title of secretary-editor. In a moment of weakness I agreed to accept the editorship if it were harmonious to the profession. The following January, I made a trek to Grand Rapids to take over the unpublished copy and to obtain details of the office from Dr. Warnshuis. He pushed over to me a desk basket containing three contributed articles which he said comprised the entire copy in his possession for future journals. One of the papers was so poor that it took the shortest route to the wastebasket.

Since that time, THE JOURNAL has been before you and gratifying to yourselves it must be, as well as to myself as editor during the past twelve years, that the demand for THE JOURNAL has increased to such an extent that notwithstanding my efforts to publish the best contributions to medical thought in Michigan, I have handed over to my successor for publication over one hundred contributions of merit. The wisdom of the Council of thirteen years ago has been fully justified insasmuch as THE JOURNAL today and for years past would have been too big a job to combine with the functions of the secretary. It is needless to say that the activities which fall to the lot of the secretary have also increased enormously during this period.

The employment of the J. R. Bruce Publishing Company as printers of THE JOURNAL has proved a happy venture. The very careful, intelligent work of the Bruce Publishing Company has greatly facilitated the work of the editor.

During the past twelve years, I have written over 700 editorials; regarding their quality I have nothing to say. I have endeavored, however, to make them timely and moderate in tone, for I am a firm believer in the persuasive power of reason over emotional appeal. Twelve years of editing has meant persistant watchfulness to see that only the best available material in the most attractive and readable form were accorded publicity and that nothing of a questionable nature got into print.

My association with the officers of the society during this twelve-year period has been intimate and happy and many have been the courtesies I have received, for which I am profoundly grateful. To mention all to whom I am obligated would make a long list.

About three years ago a request was made by the Council to keep the total number of pages (including advertising) within 100 pages. The business office as well as editorial have endeavored to follow this out to the letter as well as in spirit so that as a result, the twelve numbers comprising volume 38 contain 1,140 pages.

I now pass on the editorial mantle to my successor, and since it is a live thing and therefore capable of growth, the younger mind will expand it to larger dimensions and with it go my hope and best wishes for larger and more virile journals than ever before.

Respectfully submitted,

J. H. DEMPSTER,
Editor

The report was referred to the publication Committee.

9. *The Report of Publications Committee* was presented by the Chairman, Dr. Roy H. Holmes.

REPORT OF PUBLICATIONS COMMITTEE

The year of 1939 has been used by the Publications Committee in an attempt to reduce the cost of THE JOURNAL in proportion to the advertising contracts. While the personnel of the Committee changed somewhat at the meeting in Grand Rapids, there has been a continuous endeavor towards achieving this purpose. It has meant making some cuts in page allotment which may be distasteful to certain groups of individuals, but we felt that THE JOURNAL should be a self-sufficient and self-maintaining part of the State Society.

Besides cutting down the number of pages, the activities of the Committee have been continued in other ways. Efforts are being made in all directions to develop more advertising. An agreement now is being considered with an extra advertising solicitor for local advertisers. In order to stimulate advertising contracts we have coöperated with the advertisers in urging the readers to show an interest in the advertising in THE JOURNAL. The Central Office has worked with the Publications Committee and contacted a number of our exhibitors who were not advertising. This type of contact is bound to be of value either now or later.

The dressing-up has been done at no extra cost.

Editorially, the tendency has been toward shorter and more practical papers, using THE JOURNAL as a means of postgraduate education to the physicians. Consequently, a preference has been given to short practical papers rather than to monographs and articles written for record.

One of the major policies of the Publications Committee is to establish a wide variety of different departments of THE JOURNAL. The purpose of this is to segregate news or articles of special interest to an individual physician, and thus make THE JOURNAL more attractive to him.

The Publications Committee has the following recommendations to make to The Council for action beginning January 1, 1940:

1. The Editor's salary will be $1,200 per year plus the usual expense account allowed to officers of the Medical Society. If the correspondence necessary to the Editor's office is to be maintained in a business-like manner, it will entail the half-time services of a stenographer. This will represent an expense of about $800 per year, including postage, telegraph, etc.

2. The Editor will be permitted to name an Editorial Board of five members of the State Society whom he may call upon for advice regarding certain scientific papers.

3. All editorials which may involve the MSMS in controversial matters will be submitted to the Publications Committee of The Council for their O.K. before being accepted for publication.

4. It is felt that the executive office should take over much of the routine work regarding THE JOURNAL.

5. The Publications Committee also requests the Council to determine the amount of free space in THE JOURNAL to be given to the Michigan Medical Service and other semi-organizational activities.

6. It is requested that the advertisers be generously patronized by the officers and members of the Society.

Respectfully submitted,

ROY HERBERT HOLMES, M.D., *Chairman,*
A. S. BRUNK, M.D.
T. E. DEGURSE, M.D.
R. C. PERKINS, M.D.

The report was referred to the Finance Committee.

DR. DEMPSTER HONORED

10. *Tribute to Dr. James H. Dempster,* editor of THE JOURNAL for the past twelve years, was given by Dr. Cummings. The Chairman of the Council presented to Dr. Dempster a scroll in recognition of his long service to the Society and to Medicine, as editor of THE JOURNAL, MSMS. Dr. Dempster responded with appropriate remarks, thanking the Council for its expression of appreciation.

11. *Committee Reports.*—The following reports of committees were presented:

(a) Legislative Committee—report from Executive Secretary Burns.

(b) Industrial Health Committee—report from Executive Secretary Burns.

(c) Distribution of Medical Care Committee—report from Chairman Hartwell was read. Referred to the County Societies Committee.

(d) Maternal Health Committee—report of plans of committee from Chairman Campbell was read.

(e) Iodized Salt Committee—report from Chairman Cowie was read.

(f) Syphilis Control Committee—Minutes of December 28, 1939, meeting were read. This was referred to the Publication Committee. The Chairman of the Council was instructed to informally meet with the Committee re the item of recommended procedures in premarital examinations.

(g) Cancer Committee—Report of meeting of January 12 was given by Secretary Foster. This report was referred to the Finance Committee.

(h) Public Relations Committee—report given by Chairman Foster and referred to the County Societies Committee.

(i) Committee on Scientific Work—Dr. Foster also reported on this Committee, which was referred to the County Societies Committee.

Motion of Drs. Haughey-DeGurse that those reports which require action be referred to the appropriate Committee, the others be received and filed. Carried unanimously.

12. *Dr. Luce.*—Resignation of Dr. Luce as Chairman of the Mental Hygiene Committee was reported by President Corbus. The Chair advised the Council of the illness of Dr. Luce and reported that his condition was progressing well. Motion of Drs. Huron-Perkins that the Secretary be instructed to draft a suitable resolution and send it to Dr. Luce. Carried unanimously. Dr. O'Meara was appointed a Committee of One to send flowers to Dr. Luce.

13. *Liaison Committee with Medical Schools.*—President Corbus spoke briefly of his plan to appoint a committee to act as a liaison between the two medical schools in the study of curriculum, particularly from the standpoint of the interne. Drs. Haughey and McIntyre discussed this matter. Dr. Corbus stated the appointment of the committee would be made shortly.

RECESS.—The meeting recessed at 12:25 p. m. for luncheon.

SECOND SESSION

14. *Roll Call.*—The Council reconvened at 1:35 p. m. All members were present, including Councilors R. S. Moorish of Flint and O. O. Beck of Birmingham. Also Drs. J. D. Bruce and Carl E. Badgley of Ann Arbor, and F. C. Kidner and F. J. Fischer of Detroit.

15. *Afflicted Child Problem.*—The Chair called upon Secretary Foster to give a brief history of the problem. This matter was discussed by Dr. Cummings, who stated several principles involved: (a) the medical profession cannot strike (as a matter of public safety); (b) medical men must always furnish the highest grade of medical service possible; (c) no lay body can be allowed to set M.D. fees without consultation with physicians. Dr. Cummings stated that the final solution is a change in the policy of the administration.

The Chair called upon Drs. Badgley, Kidner and Fischer of the Orthopedic Society for suggestions.

Mr. Burns felt this is not a problem of rates and fees but a matter of control of intake. The solution of the Administration penalizes hospitals and doctors, and antagonizes them at a moment when their coöperation is necessary for the real solution—to cut the load by creation of a filter system.

Dr. Holmes read the resolution of the Muskegon County Medical Society, which was adopted by that Society on Thursday, January 11.

Motion of Drs. Cummings-Haughey that a committee be appointed by the Chair to study the suggestions made and to crystallize the thought of The Council on material to be transmitted to the County Medical Societies re this problem, and that this Committee report at a subsequent session of the Council. Carried unanimously.

Committee: Dr. Cummings, Chairman; Drs. Brunk, Foster, Huron.

16. *Postgraduate.*—The Chair called upon Dr. J. D. Bruce, who generously suggested that inasmuch as the time was limited, his subject be placed on the agenda of the Executive Committee for consideration at a subsequent date, and offered to answer any questions members of the Council might have.

RECESS.—The meeting was recessed at 3:15 p. m.

THIRD SESSION

17. *Roll Call.*—The meeting was called to order at 8:20 p. m. with all members present at the afternoon session also present at this evening's session.

18. *Minutes.*—The minutes of the First Session were read and approved.

19. *Articles of Association of MSMS* are still being studied by the Committee, the Secretary reported. Referred back to Committee for further study and report.

20. *Stephen Currie Case.*—This was presented and discussed. Motion of Dr. Cummings, seconded by several that this be referred back to the Wayne County Medical Society advising that the MSMS will be glad to coöperate if the W.C.M.S. needs any assistance. Carried unanimously.

21. *X-ray Interpretation.*—This matter had been discussed at previous meetings and referred to the Michigan Association of Roentgenologists. Letter was read from Leland E. Holly, M.D., Chairman of the Ethics Committee of the M.A.R., regarding this matter. General discussion followed. It was brought out that some hospitals in the U. P. do take x-rays and send the plates to the University Hospital and other institutions for interpretation by the X-ray Department, which department makes no charge, but some U. P. Hospitals are said to charge the regular rates to the patient. Other U. P. hospitals do the same, except they charge the patient only for taking the plate, not the interpretation. Motion by Drs. Moore-Cummings that the report of the MAR be accepted and filed. Carried unanimously.

22. *Problem of Resort Physicians* coming to Michigan during summer months and practicing without Michigan licenses was discussed. Letter from State Department Inspector was read asking the policy of the MSMS re these violations. After general discussion, motion was made by Drs. Moore-Cummings that a letter be sent to the Inspector advising him to get the evidence in these cases and present it to State Board of Registration in Medicine for action. Carried unanimously.

23. *Finance Committee.*—Chairman Carstens called upon Dr. Moore for full explanation of the 1939 Auditor's Report, after which motion was made by Drs. Holmes-McIntyre that the report of the Auditors be accepted. Carried unanimously.

24. *Drs. Beck and Morrish.*—Chairman Carstens announced the appointment of Councilor O. O. Beck to the Publications Committee, and of Councilor Ray Morrish to the Finance Committee.

RECESS—Motion of Drs. Holmes-several that the meeting recess until 9:00 A. M. January 14, 1940, the time being 9:50 P. M.

FOURTH SESSION

25. *Roll Call.*—The Fourth Session was called to order on January 14, 1940, at 9:35 A. M. with all members present.

26. *Minutes.*—The minutes of the second and third sessions were read and approved, motion of Drs. Huron-Hubbell. Carried.

27. *National Physicians Committee.*—This organization was discussed by Secretary Foster, who stated that the officers are present or past officers and others high in the A.M.A., that its objectives are in behalf of the practitioner of medicine and undoubtedly worthy of support. The Council generally discussed the matter. It was felt that the individual physician should decide if he wishes to support the work of the National Physicians Committee.

28. *Report of Individual Councilors.*—The Chair called upon each Councilor to give a report of the condition of the profession in his district. These reports were given verbally and were generally to the effect that the profession is working together harmoniously, and making progress.

29. *Report of County Societies Committee* was given by Dr. Cummings as follows:

MINUTES OF COUNTY SOCIETIES COMMITTEE

(Meeting of January 13, 1940—8 a. m.)

The Chair asked Dr. Haughey to read the report of the Committee which was given to the Council at the 1939 Midwinter meeting. Chairman Cummings stressed the necessity of coöperation by all county societies at this time. Dr. Foster urged that members of the Council must help the Public Relations Committee in bringing facts to the members of the MSMS. The Committee recommends that the Councilors act in conjunction with the Public Relations Committee in its effort to keep the membership fully advised of developments re problems associated with the afflicted-crippled child laws, medical welfare contracts, Michigan Medical Service, as well as numerous other items of much interest and importance.

The Committee also recommends that county societies add to their Committees active young men, in order to get them interested in organized medicine and to prepare them to carry on.

The Committee recommends that the Upper Peninsula Secretaries be contacted with the recommendation that the U. P. Secretaries Conference be held at the time of the U. P. Annual Meeting in July on account of adverse weather conditions in March, and to eliminate the large item of expense connected with a special meeting in the winter months.

The matter of notifying the membership that medico-legal protection is no longer furnished by the MSMS was briefly discussed. Also, that the old line companies do not cover physicians who are not members of their medical societies.

It was suggested that the National Physician's Committee should be discussed by the Council as a whole during its Mid-winter meeting.

N. Y. A. examinations were discussed. Experiences in Dickinson and Bay Counties were related.

Speakers Bureau was discussed. It was suggested that every county society have a committee to select men who are good speakers and refer their names to the Secretary of the MSMS for use in recommending speakers for county society meetings. It was also suggested that speakers of the Joint Committee might be utilized occasionally when the speaker is scheduled to talk to a lay body the same day. In these cases the Joint Committee pays the speakers' expenses.

The meeting adjourned at 10:00 a. m.

REFERENCE REPORT OF COUNTY SOCIETIES COMMITTEE

Your Committee met on January 30 at 10:30 p. m. with the following present: Drs. Cummings, Chairman; Huron, Hubbell, Sladek, Haughey, Miller and Secretary Foster.

The minutes of the morning meeting of the Committee were read and approved.

Secretary's Report—The recommendations of the Secretary were studied.

(a) Press Relations Contact. This important phase of society activity was discussed. Motion of Drs. Miller-Haughey that such a part-time press relations contact be established as soon as possible. Carried unanimously.

(b) Public Relations was discussed. Motion of Drs. Haughey-Huron that an immediate public relations drive of information to county societies and members be instituted through State Society Night meetings, attended by the Councilor, the P.R.C. member, and such other MSMS officers as may be able to attend. Carried unanimously.

(c) Speakers Bureau. Motion of Drs. Sladek-Huron that the transmission of information and facts on socialized medicine to the public be established by individual doctors of medicine in their offices and by re-created speakers bureaus in each county society. Carried unanimously.

(d) Medical Relief. Although county societies have been urged to send in their contracts re medical relief, on motion of Drs. Hubbell-Haughey we reiterate that every county society be urged to make contacts with its doctors of medicine and County Social Welfare Board re arrangements for services to welfare clients and the medically indigent; and that each Society submit tentative agreements to the State Society for advice and suggestions so that generally uniform agreements may be instituted throughout the State. This recommendation is made in order that good quality medical care may be assured and equitable fee schedules established.

(e) General Session type of program at the Annual Meeting was approved on motion of Drs. Miller-Sladek. Carried unanimously.

(f) Motion of Drs. Huron-Sladek that the Councilors be supplied with fuller notes of important actions, in order that they may appreciate the attitudes expressed in the meetings. Carried unanimously.

Motion of Drs. Sladek-Miller that the Secretary's Report be accepted as a whole. Carried unanimously.

Motion of Drs. Hubbell-Miller that the Public Relations Committee Report be approved. Carried unanimously.

The Committee commends the Committee on Distribution of Medical Care for its survey of medical fa-

cilities in Michigan, and recommends its continuance of this important work, moton of Drs. Huron-Hubbell. Carried unanimously.

Motion of Drs. Sladek-Haughey that this Committee recommend to the Council that the Committee on Scientific Work be appointed and be composed of the Secretary of the MSMS as Chairman, plus the officers of Sections, this Committee to be listed in THE JOURNAL under Committee Personnel. Carried unanimously.

Respectfully submitted,

COUNTY SOCIETIES COMMITTEE

H. H. CUMMINGS, M.D., *Chairman*
WILFRID HAUGHEY, M.D.
R. J. HUBBELL, M.D.
W. H. HURON, M.D.
A. H. MILLER, M.D.
E. F. SLADEK, M.D.

Motion of Drs. DeGurse-McIntyre that the report be accepted. Carried unanimously.

30. *Specialty Boards.*—Drs. George Goering, T. S. Conover, D. R. Brasie, R. D. Scott, and C. W. Colwell, of Flint, members of the Genesee County Medical Society, entered the meeting. The matter of specialty boards was presented in a letter from the Genesee County Medical Society read by Mr. Burns. Dr. Goering, President of the GCMS, was called upon and stated the problem of organizations requiring a physician to be certified by the American Boards, and the Boards in turn making it almost impossible for some individuals, particularly those who have been in practice for many years and who lack some of the formal graduate work. to become diplomates thereof. Dr. Brasie discussed the matter and urged that some provision be made so that these men might pass the American Boards, without discrimination. Dr. Goering read a letter from Dr. Olsen, Director of Health of the Flint Public Schools, re the Michigan Department of Public Instruction requirement that physicians be certificants of the appropriate American Board before they may examine school children for special classes. The whole matter was discussed by members of the Council. Motion of Drs. Holmes-Moore that the matter be referred to the Committee on Distribution of Medical Care, with all correspondence in the matter, for investigation of the requirements and methods of certifying by the various American Boards. Carried unanimously. The Genesee County Medical Society is to be invited to send representatives to attend the meeting of the Committee when this matter is considered.

The Chair thanked the members of the GCMS for their attendance, and they retired from the meeting.

31. *Reference Report of Publications Committee* was presented by the Chairman.

REFERENCE REPORT OF PUBLICATION COMMITTEE

The Publication Committee of the Council of the Michigan State Medical Society met and considered the items referred to it by the Council:

1. Editor's Report. This report was received and the Editor thanked for his good report on the progress of THE JOURNAL during the past year.
2. Syphilis Control Committee Report.
   (a) Proposed Letter to Paul DeKruif. This was discussed and it is the consensus of opinion of this Committee that this letter be referred to the Preventive Medicine Committee for consideration and then referred back to the Executive Committee on the Council for any action.
   (b) Item re sending representatives to Washington. This matter was discussed along with the proposed letter to Dr. DeKruif and it was felt that this should also be referred to the Preventive Medicine Committee and through that committee to the Executive Committee.

Respectfully submitted,

PUBLICATIONS COMMITTEE, MSMS

ROY H. HOLMES, M.D., *Chairman*
O. O. BECK, M.D.
R. C. PERKINS, M.D.
A. S. BRUNK, M.D.
T. E. DEGURSE, M.D.

Motion of Drs. Holmes-Perkins that the report as presented be accepted. Carried unanimously.

32. *Reference Report of the Finance Committee* was presented by the Chairman.

REFERENCE REPORT OF FINANCE COMMITTEE

Your Finance Committee had three matters referred to it: (a) report of the Cancer Committee: (b) the report of the Publication Committee; (c) the Treasurer's Report.

(a) The Finance Committee has reviewed the report of the Cancer Committee for 1939. While the budget allottment was $250.00, the Council voted to expend an additional $250.00 for a field representative, making the budget $500.00. The Cancer Committee, therefore, exceeded the budget by $98.42. While we appreciate the fine work done by this committee, we would recommend that in the coming year the Cancer Committee keep within the budgetary allottment.

(b) We accept the Treasurer's Report and recommend to the Council that quotations be obtained on Associated Gas & Electric bonds ($2,000 at 4 per cent —1978) and try to dispose of same if Treasurer Hyland concurs in the advisability of this transaction.

(c) The Report of the Publication Committee indicates a high degree of activity by this group, with tangible results apparent in the new streamlined JOURNAL of 1940.

We recommend the approval of the narrative portion of the report, and the adoption of the following recommendations as redrafted by your Reference Committee:

1. The Editor's salary of $1,200 and expense account of $600, totaling $1,800 per annum, should be allowed.
2. The Editor will be permitted to name an Editorial Board of 5 members of the State Society, subject to confirmation by the Executive Committee of the Council, whom the editor may call upon for advice regarding certain scientific papers.
3. All the editorials for the MSMS JOURNAL shall be submitted to the Publication Committee or to the Executive Committee of the Council for approval before publication.

Respectfully submitted,

Finance Committee, MSMS,
by V. M. MOORE, M.D., *Chairman*
W. E. BARSTOW, M.D.
J. E. MCINTYRE, M.D.
O. D. STRYKER, M.D.

Motion of Drs. Moore-several that the report be accepted. Carried unanimously.

33. The 1940 budget was presented by Dr. Moore and studied by the Council, item by item.

Budget for 1940

(a) Medical Secretary's Salary. This was discussed generally, and motion of Drs. Holmes-Barstow that this figure be set at $3,600 for the year. Carried unanimously.

(b) Press Relations. The Council authorized the allotment of $500 from the Educational Fund for this important work. The Council agreed that additional moneys may be needed, and approved the necessity of this additional expenditure, subject to the decisions of the Executive Committee.

(c) National Conference on Medical Service. This item was explained by Secretary Foster.

(d) Postgraduate Committee. Dr. Cummings explained that with the opening of the new center at Mt. Clemens the P. G. Committee would require $2,400 for its budget. This was approved on motion of Drs. Cummings-DeGurse. Carried unanimously.

(e) Syphilis Control. Dr. Holmes voiced his objection to the decrease in allottment for the Syphilis Control Committee from $500 to $300.

Motion of Drs. Haughey-Miller that the 1940 Budget as presented and revised be approved. Carried unanimously.

M.S.M.S. BUDGET

INCOME:	
4,300 members at $12 (plus ½ and ¼ dues of new members)	$52,050.00
Interest	100.00
Miscellaneous Income	75.00
Total Income	$52,225.00
Less Allocation to THE JOURNAL at $1.50	6,506.25
Total Net Income	$ 45,718.75
APPROPRIATIONS:	
Administrative and General:	
Medical Secretary Salary	$ 3,600.00
Executive Secretary Salary	7,000.00
Other Office Salaries	5,100.00
Extra Office Help	900.00
Office Rent	1,235.00
Printing, Stationery and Supplies	1,000.00
Postage	950.00
Insurance and Fidelity Bonds	190.00
Auditing	265.00
New Equipment and Repairs	300.00
Telephone and Telegraph	600.00
Miscellaneous	50.00
Total	$ 21,190.00
Less Expenses Redistributed to JOURNAL	$ 1,800.00
Total Admin. and General	$ 19,390.00
Society Expense:	
Council Expenses	$ 3,000.00
Delegates to A.M.A.	900.00
Secretaries Conferences	1,000.00
General Society Travel Expense	2,500.00
Secretary's Letters	500.00
Publication Expense	500.00
Reporting Annual Meeting	140.00
Michigan Medical Service	2,400.00
Education Expenses	2,000.00
Sundry Society Expenses	1,125.00
National Conference on Medical Service	400.00
Organizational Expense	2,175.00
Legal Expense	750.00
Woman's Auxiliary—Annual Meeting	200.00
Contingent Fund	1,993.75
Total	$ 19,583.75
Less Gain from Annual Meeting	$ 1,800.00
Net Society Expense	$ 17,783.75
Committee Expenses:	
Legislative Committee	$ 1,000.00
Distribution of Medical Care	150.00
Representatives to Joint Committee	800.00
Preventive Medicine	400.00
Cancer	600.00
Child Welfare	250.00
Iodized Salt	20.00
Heart & Degenerative Diseases	100.00
Industrial Health	200.00
Maternal Health	200.00
Mental Hygiene	100.00
Radio	25.00
Syphilis Control	300.00
Tuberculosis Control	100.00
Public Relations	1,000.00
Ethics	100.00
Membership	25.00
Advisory Committee to Woman's Auxiliary	50.00
Scientific Work Committee	100.00
Postgraduate Medical Education	2,400.00
Sundry Other Committees	325.00
Committee Reserve	300.00
Total Committee Expenses	$ 8,545.00
GRAND TOTAL	$ 45,718.75

34. *Budget of* THE JOURNAL for 1940 was presented by Dr. Moore.

BUDGET OF THE JOURNAL

It was explained that under Editor's Salary, the amount includes $1,200 for 1940 salary, $250 salary for Dr. Dempster for December, 1939, and $100 salary and $50 expenses to Dr. Holmes for his work in preparing the January issue of THE JOURNAL. Motion of Drs. Moore-McIntyre that the 1940 budget for THE JOURNAL be approved with this change. Carried unanimously.

BUDGET FOR THE JOURNAL, 1940

INCOME:		
Subscriptions from members	$6,506.25	
Other subscriptions	75.00	
Advertising Sales	10,000.00	
Reprint Sales	1,500.00	
Journal Cuts	125.00	
		$18,206.25
EXPENSES:		
Editor's Salary	$1,600.00	
Editor's Expense	600.00	
Printing and Mailing	9,000.00	
Cost of Reprints	1,500.00	
Allocation of administrative and general expense	1,800.00	
Discounts and commissions on advertising sales	1,600.00	
Postage	250.00	
Reserve	1,856.25	
		$18,206.25

35. *Country Gentleman Article.*—This article, "The People Demand Public Health" written in the October-December, 1939, and January, 1940 issues of *Country Gentleman* by Dr. Paul DeKruif was called to the attention of the Council by the Chairman. The January article commends the Michigan State Medical Society and its plan of group medical care—"Michigan Medical Service." Motion of Drs. Haughey-Huron that a letter of appreciation be sent to the Editor of *Country Gentleman* and to Paul DeKruif. Carried unanimously.

36. *M.S.G.H. Offer.*—Chairman Carstens reported that the Michigan Society for Group Hospitalization is offering its service to members of the MSMS shortly.

37. *MSMS Annual Meeting of 1940.*—The Council, on motion of Drs. Cummings-several, appointed Dr. Allan McDonald, Detroit, President-elect of the WCMS, as General Chairman of Local Arrangements; and Dr. C. D. Brooks, Detroit, as Chairman of the Golf Committee, in connection with the Detroit 1940 Convention. Carried unanimously.

38. *Report of Special Committee on Afflicted-Crippled Child was presented.*

REPORT OF SPECIAL COMMITTEE ON AFFLICTED-CRIPPLED CHILD

Four factors enter into the problem of the afflicted and crippled child, *vis.*:

(a) Statutes providing state aid
(b) Inadequate appropriations
(c) An unpredictable commodity (sickness)
(d) An established fee-schedule.

The Statutes were revised in 1939 and gave the Crippled Children Commission more power in the control of committments, but failed to provide funds for the employment of coördinators.

In the words of Governor Dickinson, the appropriations were too drastically cut.

Sickness being an unpredictable commodity, deficits

in appropriations may occur. The determination of the case-load is not the great problem, but the determination of what proportion of the case-load is the responsibility of the State and what part is the responsibility of the family, is the problem—in other words, the problem is one of efficient economic filtering.

In 1933, fee schedules A and C were established in conference of the Crippled Children Commission and the MSMS and were based on costs to the physician of rendering the services. Any reduction in these schedules is demanding a service at less than its cost of production. This is not done by the State in the purchase of any other commodity or service.

Any other group would refuse to render service or supply commodities on such a basis; but in the interests of public safety, physicians, as a group, cannot "strike."

The physicians of Michigan recognize only one quality of medical care—the best; and the children of Michigan, irrespective of their economic status, are entitled to this quality of medical and surgical care.

Due to the nature of medical and surgical services, no lay organization can set equitable fees for such services without consultation with the medical profession.

Should schedules A and C be reëstablished the doctors of the State of Michigan might well adopt the plan of coöperating with the State of Michigan and the Crippled Children Commission by reëstablishing the Medical Filter Board in all counties of the state—these boards to pass on medical and surgical need and urgency—providing the Crippled Children Commission will enforce the Economic Filter, free from political intrigue.

In the event that schedules A and C are not reestablished by the C.C.C., rather than accept ridiculously low fees, the physicians of Michigan might well return to their traditional right of rendering charity to the individual (not the State) whom they personally determine so deserving.

This imposition on the medical profession may persist until such a time as we have a change in the policy of the state administration or the time when it can be made a legislative issue in which the laborer is considered worthy of his hire.

Motion of Drs. Haughey-Hubbell that the report be accepted. Carried unanimously.

The question of publicity on the policy of the M.S.M.S. re this matter was discussed and motion made by Drs. Cummings-several that the Chairman of the Council, Secretary, and Executive Secretary and one additional member be appointed by the Chair, act as a Press Committee for this matter. Carried unanimously. The Chair appointed Dr. H. H. Cummings as the other member of the above committee.

ELECTIONS AND APPOINTMENTS

39. *Medical Legal Committee.*—President Corbus presented his appointments for the Medical Legal Committee for 1940 as follows: S. W. Donaldson, M.D., Chairman, Ann Arbor; E. A. Wittwer, M.D., Bay City; L. G. Christian, M.D., Lansing; Wm. J. Stapleton, Jr., M.D., Detroit; and E. O. Foss, M.D., Muskegon. Motion of Drs. McIntyre-Perkins that the appointments be approved. Carried unanimously.

40. *Election of Secretary*—L. Fernald Foster, M.D., was nominated for Secretary by Drs. Perkins-McIntyre. Motion of Drs. Huron-Holmes that the nominations be closed and the Executive Secretary be instructed to cast the unanimous ballot for Dr. Foster as Secretary. The Executive Secretary did so cast.

41. *Election of Treasurer.*—Wm. A. Hyland, M.D., was nominated by Dr. McIntyre, seconded by several. Motion of Drs. Barstow-Miller that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Hyland as Treasurer. Carried unanimously. The Secretary did so cast.

42. *Election of Editor.*—Roy Herbert Holmes, M.D., Muskegon, was nominated for Editor of THE JOURNAL by Dr. Haughey, seconded by Drs. Miller and Brunk. Motion of Drs. DeGurse-Perkins that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Holmes, as Editor. Carried unanimously. The Secretary did so cast.

43. *Resignation of Dr. Holmes as Chairman of the Publication Committee.*—Dr. Holmes presented his resignation as Chairman of the Publication Committee, which was accepted on motion of Drs. McIntyre-Sladek. Carried unanimously.

Election of Chairman of Publication Committee.—Wilfred Haughey, M.D., Battle Creek, was nominated for Chairman of the Publication Committee by Dr. McIntyre, seconded by Dr. Sladek. Motion of Drs. DeGurse-Barstow that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Haughey. Carried unanimously. The Secretary did so cast.

44. *Appointment of Executive Secretary.*—Wm. J. Burns was nominated by Dr. O. D. Stryker, seconded by Dr. McIntyre. Motion of Drs. Miller-Huron that the nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Mr. Burns. Carried unanimously. The Secretary did so cast.

45. *Adjournment.*—The meeting was adjourned at 1:50 p. m., the Chair thanking all for their attendance, good advice and help and patience during the long sessions.

REPORT OF AUDITORS FOR 1939

We have examined the balance sheet of the Michigan State Medical Society as of December 20, 1939, and the statements of income and expense for the fiscal year ended at that date, have reviewed the system of internal control and the accounting procedures of the Society and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate.

The Society was organized under the laws of the State of Michigan on September 17, 1910, as a corporation not for pecuniary profit. It is affiliated with the American Medical Association and charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes, the Society publishes "The Journal of the Michigan State Medical Society."

Balance Sheet

A summary of the balance sheets at December 20, 1939, and December 24, 1938, follows:

ASSETS	DEC. 20, 1939	DEC. 24, 1938	INCREASE DECREASE*
Cash	$13,293.22	$ 9,650.78	$ 3,642.44
Notes and accounts receivable, less reserve	1,350.94	5,274.35	3,923.41*
Securities—at cost, less reserve	28,667.50	28,779.00	111.50*
Deferred charges	88.25	117.42	29.17*
	$43,399.91	$43,821.55	$ 421.64*
LIABILITIES			
Accounts payable	$17,418.06	$ 1,284.04	$16,134.02
Liability for fund administered	—o—	39.37	39.37*
Unearned income	1,757.50	6,671.00	4,913.50*
Reserve for Medico-Legal Defense Fund	—o—	9,225.30	9,225.30*
Net worth	24,224.35	26,601.84	2,377.49*
	$43,399.91	$43,821.55	$ 421.64*

Notes receivable for dues represent the uncollected portions of notes taken in settlement of 1931, 1932 and 1933 dues. No payments were received on these notes during the year ended December 20, 1939.

Accounts receivable for advertising, reprints and cuts were analyzed as to date of charge and are classified in comparison with the balances at December 24, 1938, as follows:

DATE OF CHARGE	DECEMBER 20, 1939 Amount	Per Cent	DECEMBER 24, 1938 Amount	Per Cent
October, November and December	$1,221.65	84.40%	$ 946.58	73.26%
July, August and September	59.75	4.13%	198.50	15.37%
January to June, inclusive	33.17	2.29%	22.47	1.74%
Prior to January 1st	132.90	9.18%	124.45	9.63%
TOTAL	$1,447.47	100.00%	$1,292.00	100.00%

The balances due from county societies represent dues collected for the Society by two county societies and impounded in depositary banks. As funds are released by the banks, the Society's share is to be forwarded by the county societies. No payments were received during the year on these accounts.

Based upon our analysis of the notes and accounts receivable and a discussion of their collectability with employees of the Society, it is our opinion that the reserve in the amount of $325.00 is sufficient to provide for collection losses anticipated at the date of this report.

A schedule of securities owned is included in a later section of this report and sets forth the principal amount, cost and quoted market prices at December 20, 1939. Unlisted securities have been valued from information furnished by brokers as to the current bid and sale prices. During the year, bonds owned by the Society in the principal amount of $4,000.00 were called, and the proceeds were reinvested. The proceeds from the called bonds were slightly in excess of their cost to the Society. Matured coupons not cashed at December 20, 1939, have been included at face amount, but no other accrued interest has been included in the balance sheet.

During the year, the Society was active in the promotion and formation of a group medical organization under terms of recently enacted state legislation, the organization to be known upon formal incorporation as the Michigan Medical Service. We understand that expenditures made by the Society in this connection are to be repaid by the Michigan Medical Service only from earnings of the latter organization with the permission of the State Insurance Department. The Society has also agreed (although the contract relative thereto had not been signed at December 20, 1939) to furnish working capital in the amount of $10,000.00 to the Michigan Medical Service, which amount is also to be repaid from earnings. It is anticipated that formal incorporation and the commencement of operations of the Michigan Medical Service will take place shortly after January 1, 1940. Due to the uncertainty of realizing on the advances made for organization expenses, and the advances to be made for working capital, a reserve of $16,760.68 has been provided for possible loss of the total amount.

Deferred charges as shown in the balance sheet represent costs incurred prior to December 20, 1939, in connection with advertising for the 1940 annual meeting. In accordance with established policy, such items are properly chargeable to future operations.

Provision has been made for all known liabilities as of December 20, 1939. No provision has been made, however, for any liability the Society might have in connection with pay roll taxes for the years 1936 to 1939, inclusive.

Collections of 1940 dues and overpayments of dues for prior years have been shown as unearned income.

During the year, action was taken to eliminate the Medico-Legal Defense Fund Reserve, and by action of the Executive Committee of the Council on December 15, 1939, it was determined that cash and securities in the amount of $6,000.00 should be transferred to Wm. A. Hyland, M.D., as trustee, to provide for liability for medico-legal defense incurred to December 31, 1939, and that the balance of the Medico-Legal Defense Fund be turned in to the general assets of the Society. We have included herein a schedule which shows a summary of the changes in this reserve during the year. In the preparation of this schedule, the allocation of the $6,000.00 to the trustee and the transfer of the balance of the reserve to the net worth account of the Society has been made as of the close of the fiscal year, December 20, 1939. During the year, no

portion of the dues collected was allocated to the fund, the only receipts being interest and dividends on securities which have heretofore been classified as belonging to the Medico-Legal Defense Fund. The adjustment of the reserve to reduce securities to aggregate quoted market prices was made on the basis of prices existing immediately prior to the elimination of the fund. This adjustment resulted in a charge of $541.50 to the Medico-Legal Defense Fund Reserve. In the future, all income on securities owned by the Society, except such as might be turned over to the trustee in partial settlement of the $6,000.00 trust fund, will be credited to the income account of the Society, and any adjustments of the reserve to reduce securities to the quoted market prices will be made through the net worth account of the Society.

The increase in income from membership fees was the result of an increase in the membership of the Society.

As in prior years, $1.50 of each member's annual membership fee has been allocated to subscription income of "The Journal of the Michigan State Medical Society." The decrease in income from the JOURNAL is a result of the fact that during the latest fiscal year the JOURNAL was charged with $1,800.00 as its share of the expenses of the executive offices, whereas in preceding years no part of these expenses has been charged to the JOURNAL.

Comparative statements of income from the JOURNAL and of the expenses of the Society for the fiscal year ended December 20, 1939, and the preceding fiscal year are included herein.

Scope of Examination

The scope and nature of our examination are outlined in the following comments:

The demand and savings deposits were confirmed by correspondence with the depositary banks and by reconcilement of the balances reported by them to the amounts shown in the balance sheet. The office cash fund was counted on the morning of December 21, 1939. The totals of each of the bank deposits during three months of the year as shown in the cash receipts book were compared with the credits shown on bank statements on file, and the monthly totals of bank deposits, as shown in the cash receipts book, were compared with the monthly totals of cash receipts as recorded therein. The recorded cash disbursements for three months of the year were compared with cancelled bank checks, invoices and other memoranda. To the extent of the tests made, no irregularities were disclosed.

Notes receivable were inspected by us. Accounts receivable were in agreement with trial balances of the individual accounts. We did not correspond with any of the debtors to confirm the accuracy of the book records. The amount shown as due from the Grand Rapids Trust Company was in agreement with the records of that company.

Securities were inspected on December 20, 1939, and market quotations were obtained to ascertain their market prices at that date. Uncashed coupons at December 20, 1939, were accounted for by a receipt from the bank where they had been placed for collection which was submitted for our inspection.

We did not correspond with recorded creditors of the Society to confirm the liabilities at December 20, 1939; however, we examined unpaid invoices, expense reports, et cetera, received subsequent to that date, to ascertain that all liabilities have been provided for.

In addition to our examination of the items included in the balance sheet, we made tests of transactions entering into the income and expense accounts. Unused membership certificates were examined to check the income from dues. Interest income accrued for the year on bond investments was accounted for. Tests of advertising income were made by comparison of billings for advertising with space used in three issues of the JOURNAL. We also reviewed the items charged to the major expense accounts for the year.

Opinion

In our opinion, the accompanying balance sheet and related statements of income and expense present fairly the position of the Michigan State Medical Society at December 20, 1939, and the results of its operations for the fiscal year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

ERNST & ERNST, *Certified Public Accountants.*

BALANCE SHEET
MICHIGAN STATE MEDICAL SOCIETY
December 20, 1939

ASSETS

Cash				
Demand deposit			$ 3,172.37	
Office cash fund			3.74	
Savings deposits			10,117.11	
				$13,293.22
Notes and Accounts Receivable				
Notes receivable for dues—past due		$ 80.00		
Accounts receivable:				
For advertising, reprints, cuts, etc.	$1,447.47			
From county societies for dues	75.19	1,522.66		
			$ 1,602.66	
Less reserve			325.00	
			$ 1,277.66	
Grand Rapids Trust Company			73.28	
				$ 1,350.94
Securities				
Bonds and stock—at cost		$34,737.50		
Less reserve to reduce to aggregate quoted market prices		6,215.00	$28,522.50	
Matured coupons on bonds			145.00	
				$28,667.50
Michigan Medical Service				
Organizational expenditures made by the Michigan State Medical Society		$ 6,760.68		
Proposed advance for working capital, provided for as a liability		10,000.00	$16,760.68	
Less reserve			$16,760.68	
				—o—
Deferred Charges				
Expenses in connection with 1940 annual meeting				88.25
				$43,399.91

REPORT OF AUDITORS FOR 1939

LIABILITIES

Accounts Payable		
For current expenses, etc.	$ 1,418.06	
To Michigan Medical Service	10,000.00	
To Wm. A. Hyland, M.D., trustee	6,000.00	
		$17,418.06
Unearned Income		
Dues for the year 1940		1,757.50
Net Worth		
Balance at December 24, 1938	$26,601.84	
Net decrease for the fiscal year ended December 20, 1939	2,377.49	
		$24,224.35
		$43,399.91

INCOME AND EXPENSE STATEMENT
MICHIGAN STATE MEDICAL SOCIETY
FISCAL YEAR ENDED DECEMBER 20, 1939

INCOME:		
Membership fees	$51,518.00	
Less portion allocated to JOURNAL income for subscriptions	6,439.75	
	$45,078.25	
Income from JOURNAL—as shown by schedule	825.27	
Interest received	763.06	
Miscellaneous	84.37	
Total Income		$46,750.95
EXPENSES—AS SHOWN BY SCHEDULE:		
Administrative and general	$17,368.00	
Society activities	10,534.81	
Committee expenses	6,873.43	
	$34,776.24	
Excess of Income over expenses		$11,974.71
OTHER INCOME:		
Reduction in reserve for notes and accounts receivable	$ 102.00	
Profit on sale of securities	46.50	
	$ 148.50	
Net Income		$12,123.21
ADJUSTMENTS TO NET WORTH:		
Deductions:		
Provision for loss on organization expenses incurred for Michigan Medical Service	$ 6,760.68	
Provision for loss on advances to be made to Michigan Medical Service	10,000.00	
	$16,760.68	
Additions:		
Reduction of reserve to reduce securities owned to quoted market prices	$ 333.75	
Transfer of balance of Medico-Legal Defense Fund Reserve	1,926.23	
	$ 2,259.98	
	$14,500.70	
Decrease in Net Worth		$ 2,377.49

INCOME FROM "THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY"
MICHIGAN STATE MEDICAL SOCIETY
Fiscal years ended December 20, 1939, and December 24, 1938

	YEAR		INCREASE
	1939	1938	DECREASE*
INCOME			
Subscriptions from members	$ 6,439.75	$ 6,151.12	$ 288.63
Other subscriptions	82.00	112.00	30.00*
Advertising	11,051.29	10,269.20	782.09
Reprint sales	1,767.43	1,857.98	90.55*
Journal cuts	263.45	166.96	96.49
	$19,603.92	$18,557.26	$ 1,046.66
EXPESNSES			
Editor's salary	$ 2,750.00	$ 3,000.00	$ 250.00*
Editor's expense	50.00	600.00	550.00*
Printing and mailing	10,567.66	10,144.90	422.76
Cost of reprints	1,367.95	1,423.21	55.26*
Discounts and commissions on advertising	—o—	1,196.17	796.87
Postage	250.00	250.00	—o—
Allocation of administrative and general office expenses	1,800.00	—o—	1,800.00
	$18,778.65	$16,614.28	$ 2,164.37
Net Income	$ 825.27	$ 1,942.98	$ 1,117.71*

EXPENSES
MICHIGAN STATE MEDICAL SOCIETY
Fiscal years ended December 20, 1939, and December 24, 1938

	YEAR		INCREASE
	1939	1938	DECREASE*
ADMINISTRATIVE AND GENERAL			
Secretary's salary	$ 2,400.00	$ 2,400.00	$ —o—
Executive secretary's salary	7,000.00	6,000.00	1,000.00
Other office salaries	5,351.75	4,000.05	1,351.70
Office rent	1,042.50	720.00	322.50
Printing, stationery and supplies	1,190.32	989.91	200.41
Postage	846.87	738.02	108.85
Auditing	265.00	250.00	15.00
Insurance and fidelity bonds	187.10	190.77	3.67*
Telephone and telegraph	598.60	460.55	138.05
Legal expense	—o—	35.00	35.00*
New equipment	263.84	994.78	730.94*
Unclassified	22.02	170.18	148.16*
	$19,168.00	$16,949.26	$ 2,218.74
Less expense redistributed to "Journal"	1,800.00	—o—	1,800.00
	$17,368.00	$16,949.26	$ 418.74

SOCIETY ACTIVITIES			
Council expenses	$ 2,508.57	$ 3,012.50	$ 503.93*
Educational fund	3,000.00	–o–	3,000.00
Delegates to American Medical Association	618.78	1,675.56	1,056.78*
Secretaries' conference	1,231.13	740.61	490.52
Secretary's letters	423.24	523.28	100.04*
Traveling	2,849.51	2,218.63	630.88
Legal expense	157.50	–o–	157.50
Reporting annual meeting	136.61	130.39	6.22
Publications	346.67	18.90	327.77
Michigan Medical Service	263.73	–o–	263.73
Sundry society expense	1,103.30	849.97	253.33
	$12,639.04	$ 9,169.84	$ 3,469.20
Less revenue from annual meeting in excess of cost thereof	2,104.23	1,514.44	589.79
	$10,534.81	$ 7,655.40	$ 2,879.41

EXPENSES—CONTINUED

	YEAR		INCREASE
COMMITTEE EXPENSES	1939	1938	DECREASE*
Legislation committee	$ 1,325.60	$ 775.29	$ 550.31
Committee on distribution of medical care	113.22	676.12	562.90*
Contribution to Joint Committee on Public Health Education	500.00	875.00	375.00*
Cancer committee	598.42	802.95	204.53*
Contribution to Michigan Infantile Paralysis Commission	1,000.00	–o–	1,000.00
Preventive medicine committee	204.01	119.51	84.50
Postgraduate conferences	2,022.26	1,328.80	693.46
Public relations committee	225.43	509.10	283.67*
Advisory committee on women's auxiliary	234.50	110.74	123.76
Advisory committee on syphilis control	226.54	93.10	133.44
Committee reorganization expense	–o–	31.75	133.87
Maternal welfare committee	165.62	150.10	150.10*
Iodized salt committee	–o–	286.25	286.25*
Ethics committee	–o–	42.72	42.72*
Sundry other committees	257.83	334.14	76.31*
	$ 6,873.43	$ 6,135.57	$ 737.86
Total	$34,776.24	$30,740.23	$ 4,036.01

IF YOU DISPENSE, READ THIS

Physicians who dispense their own drugs must comply with the provisions of the Federal Food, Drug and Cosmetic Act, particularly Section 502-b. This section provides that a drug or device shall be deemed misbranded "If in package form unless it bears a label (1) showing name, place of business of manufacturer, packer or distributor; (2) an accurate statement of the quantity of the contents in terms of weight, measure, or numerical count, reasonable variation permitted."

As the law is written, it applies to physicians who dispense their own drugs, as well as to pharmaceutical houses, pharmacists, drug stores, or anyone who manufactures or distributes drugs. The physician (and the drug store or pharmacist) is exempt from these labeling provisions, *only* IF he writes a prescription and sends the patient to the druggist for the medicine.

Other parts of Section 502 are also of interest to physicians, such as Part D re labeling of narcotic drugs as "habit forming" unless on written prescription which is marked unrefillable; Part E requiring the common or usual name of the drug, if one, to be written on the label; or the names of the active ingredients giving the proportion or quantity of bromides, ether, chloroform, acetanilid, acetphenetidin, amidopyrine, antipyrine, atrophine, hyoscine, hyoscyamine, arsenic, digitalis, digitalis glucosides, mercury, ouabain, strophanthin, strychnine, thyroid, or any derivatives of such substances, UNLESS given in a written prescription: Part F requiring adequate directions for use.

The aim of the law, of course, is to eliminate "counter prescribing" by drug stores and harmful self-medication with highly potent and often dangerous drugs. It is not known just how strenuously the Federal Food, Drug and Cosmetic Administration will require physicians who dispense to adhere to this particular portion of the law, but it is a federal statute and should be complied with.

NATIONAL CONFERENCE ON MEDICAL SERVICE

PALMER HOUSE, CHICAGO, SUNDAY, FEBRUARY 11, 1940

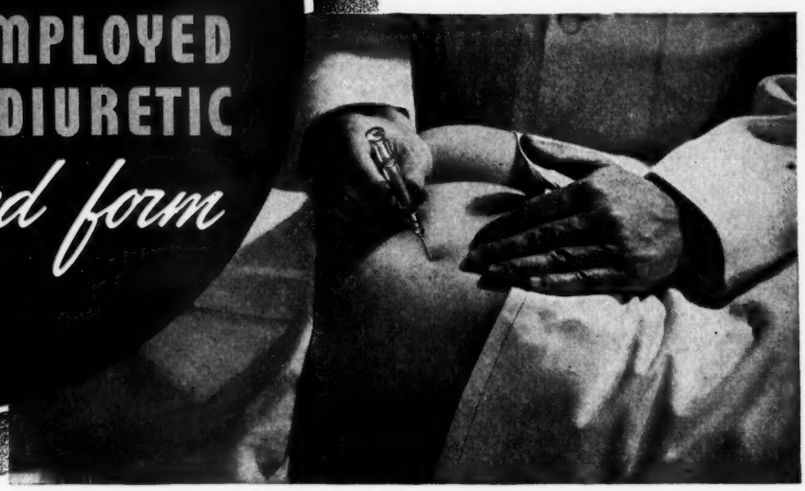
YOUR ARE INVITED

PROGRAM ON PAGE 125

Now

A WIDELY EMPLOYED MERCURIAL DIURETIC *in improved form*

Excellent for
INTRAMUSCULAR
and
INTRAVENOUS INJECTION



IT has been conclusively proved that the association of theophylline with a mercurial diuretic greatly enhances the local tolerance to the mercurial component. After intramuscular administration, the mercury component is absorbed more rapidly and completely from the site of injection, the rate of excretion is proportionately increased, and the diuretic effect is more prompt and more pronounced than when the mercurial alone is administered.

Salyrgan-Theophylline (10 per cent of Salyrgan* with 5 per cent of theophylline in solution) is absorbed quickly (97 per cent within an hour) and entirely from muscle tissue. As a result local soreness and pain are greatly reduced in intensity or not experienced at all.

Write for booklet describing Salyrgan-Theophylline, including discussion of dosage, directions for use and contraindications and side effects.

* Mercury salicylallylamide-o-acetate of sodium.

HOW SUPPLIED: Salyrgan-Theophylline solution is supplied in ampules of 1 cc., boxes of 5 and 25; and ampules of 2 cc., boxes of 10 and 25.

SALYRGAN-THEOPHYLLINE

"Salyrgan," Trademark Reg. U. S. Pat. Off. & Canada

ACCEPTED AMERICAN MEDICAL ASSN.

Brand of MERSALYL
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Pharmaceuticals of merit for the physician

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MICHIGAN'S DEPARTMENT OF HEALTH

HENRY A. MOYER, M.D., Commissioner, Lansing, Michigan

HEALTH OF THE STATE IN 1939

The Michigan Department of Health at the close of 1939 looks back on a year of gains and improvements in the health of the state, and forward to the problem of organizing community health services in rural areas not yet afforded such protection.

The past year was the safest in the state's history in which to be born. New low records were set in infant and maternal mortality.

New preventive and control measures for certain communicable diseases were put into general use during 1939. New studies and experimental work were begun for others.

Three new counties established county health departments during the year, bringing the number of organized counties to 61. Twenty-two counties still do not provide full time local health service for their residents.

BIRTH AND DEATH RATES

Encouraging Statistics

Based on provisional statistics for the first ten months of 1939, the new low record for infant deaths is 41.7 per 1,000 births. The new figure eclipsed a record set the year before at 44.54 deaths per 1,000 births. Before 1938, the next best record for the state was 47.71 in 1935. For 10 months, the 1939 record means that 309 fewer babies died than in 1938.

There was a decrease in maternal deaths, which is viewed as equally note-worthy. In 1939, the maternal mortality was 3.1 per 1,000 births, a figure just half that of ten years ago. The 1938 rate was 3.56.

In 1940, the Department plans to make available at several centers in the state, incubators for the care of premature infants. More than 1,400 babies died last year because they were born prematurely. Premature birth is the largest single cause of death among infants.

Heart disease, cancer, nephritis and diabetes largely account for a rise in the general death rate in 1939 from 9.9 to 10.2 per 1,000 persons. But children born today can expect to live an average of ten years longer than those born only a generation ago.

Births declined in 1939 to 18.4 per 1,000 population as compared with 19.3 per 1,000 in 1938. This may be partly explained by the drop in the number of marriages the year before. Marriages increased 23 per cent in 1939, so that the 1940 birth rate may be expected to overcome the drop of this year.

Advances

This fall, the Health Department started free distribution to physicians of its new pertussis vaccine. The new vaccine has proved effective in nearly four years of field testing.

Against another communicable disease—pneumonia—the state is waging a general campaign. With the aid of two new weapons, antipneumococcic serum and sulfapyridine, physicians believe that the pneumonia death rate may be reduced 50 per cent or more.

During the year, the Health Department laboratories responded to a 25 per cent increase in demand for services to health officers and doctors. Examinations of more than 500,000 specimens were made. About 200,000 were blood tests for syphilis. A new branch laboratory was established at Powers to serve the eastern end of the Upper Peninsula.

A rural sanitation law was passed by the 1939 legislature, and as a result an attack is being made on conditions which may cause typhoid, diarrhea and dysentery in rural and resort areas.

One of the least publicized but most important public health gains during 1939 is the improvement of public water supplies. Due to municipal construction during the year, every community in the state of over 1,000 population has a public water supply.

EDUCATION

Education in public health matters has continued as a basic policy of the Health Department. The Department has helped to sponsor training on the job for public health personnel, postgraduate and consulting opportunities for doctors and dentists, and health information for the public. More than a million health pamphlets annually go to Michigan readers. Last year 125,000 persons attended health lectures, child care classes and women's classes sponsored in 74 counties.

The combination of a "health conscious" public aroused to personal and community health needs, plus capable medical and public health workers has proved an effective answer to the challenge of the preventable diseases.

AUTOPSY MATERIAL REQUIRED FROM SUSPECTED RABIES CASES

"Whenever a suspected case of human rabies comes to autopsy, the person making the autopsy shall be responsible for immediately transferring a portion of the brain and spinal cord to the State Laboratories in Lansing for pathological examination and animal inoculation. A history of the case shall accompany the specimen."

"True health security," said Dr. Peter Irving of New York City, secretary and general manager of the New York Medical Society, "exists in the ability of the medical profession to pass over to the public new scientific knowledge. Last year there were lectures in seventeen counties, spreading postgraduate education to physicians who do not live near teaching centers, in addition to the regular scientific sessions of county societies and at the annual state society meeting. Other organizations are working toward the same end. In this state the public can get all the medical care they need and it is of the best quality."—From *Medical News,* Medical Society of the State of New York.

Citrus fruits are a healthful natural food, supplementing and repairing the deficiencies of the usual American diet which is notoriously poor in vitamins and mineral salts. Therefore any dietary habit which will increase the consumption of these valuable fruits should benefit the public health. Counsel to augment the customary intake of fruit by the addition of grapefruit and tangerines to the diet should help to raise the "ill-fed third" of the population to the "minimum" protective level of vitamin and mineral intake, and to increase the intake of the better-fed to that "optimum" level which is requisite for buoyant and abounding health.—Florida Citrus Commission.

Woman's Auxiliary

BRIEFS

Bay County: Meeting of December 15 was held at the home of Mrs. A. D. Allen, president, with thirty-seven members present. Speaker: Miss Libby Kessler, who reviewed "Dr. Hudson's Secret Journal."

Gratiot-Isabella-Clare County: Joint meeting of the medical society and its Woman's Auxiliary was held at the Wright Hotel, Alma, on December 21, with ninety present. Wm. J. Burns, Executive Secretary, Michigan State Medical Society, spoke on "Opportunities for the Doctor's Wife."

Ingham County: At the January 15 meeting, Wm. J. Burns, Executive Secretary of the State Society, discussed "Michigan Medical Service."

Jackson County: The Auxiliary members were guests of the County Medical Society on December 15, with 120 members present. The dinner-dance was in charge of Dr. and Mrs. John Ludwick, Dr. and Mrs. C. D. Munro, Dr. and Mrs. Grant Otis, Dr. and Mrs. Rex Bullen, Dr. and Mrs. Dean Smith, and Dr. and Mrs. R. H. Alter.

Kalamazoo County: The Auxiliary was guest of the Kalamazoo Academy of Medicine at a Christmas party at the Park American Hotel, December 19. One hundred twelve were present. Dr. Paul W. Harrison, the "Desert Doctor," spoke of "Medical Experiences in Arabia."

Lapeer County: Forty members of the medical society and the Woman's Auxiliary were guests of Dr. and Mrs. J. O. Thomas at dinner on December 3. A business meeting was held after the dinner.

Oakland County: Members were entertained November 17 at a coöperative luncheon at the home of the president, Mrs. Harry B. Yoh, at Clarkston. Plans were made for entertaining the husbands of the members at an informal dinner-dance in January.

Saginaw County: Forty members attended a luncheon meeting at the home of Mrs. S. A. Sheldon, Saginaw.

Members voted to contribute to the purchase of an iron lung, and to send *Hygeia* to twenty rural schools and the First Ward Community Center. Mrs. Milton G. Butler was general chairman for the meeting. Husbands will be invited to the next meeting.

Washtenaw County: The December meeting was held at the home of Mrs. Max Peet. The January 9 meeting was a hobby show at the home of Mrs. S. L. LaFever.

Wayne County: The November meeting was held in the club house on November 10. Dr. Nathan Sinai, of the University of Michigan, spoke on "Highways and Horizons of Medicine in This Changing World." The lecture was followed by a most enjoyable tea hour.

The Wagner Health Bill, medicine in foreign countries, and the future of American medicine will be discussed at following meetings.

Sixty new members of the Auxiliary were introduced by Mrs. Charles Barone, Chairman of the Membership Committee, at a musical tea in the Wayne County Medical Society headquarters on December 8. Speakers were Drs. J. Milton Robb and Edward D. Spalding on "The Wagner Health Bill."

The Annual Children's Christmas Party was held at the W.C.M.S. headquarters on December 16, the main feature being a puppet show for the children and a visit from Santa Claus.

SCHIZOPHRENIA

(Continued from page 117)

sympathetic nervous system disorder known to be present in schizophrenia.

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Mississippi Valley Medical Society

The sixth annual meeting of the Mississippi Valley Medical Society will be held at the Hotel Fort Armstrong, Rock Island, Illinois, September 25, 26, 27, 1940. Dr. James Gray Carr, A.B., M.D., F.A.C.P., of Chicago, Secretary and Professor of Medicine, Northwestern University School of Medicine, was awarded the Mississippi Valley Medical Society's Distinguished Service Award for 1939, for "unusual and distinguished service to the medical profession."

"This is recognition of his innate sincerity, his deep understanding of medical problems, his kindly ministrations with a fine basic personality."

Farm Security

The Farm Security administration recently issued the following report pertaining to F.S.A. Medical plans now operating in Kansas:

Total Number of Families Included	1,884
Total Number of Persons Included	10,646
Amount Paid for Physicians Services during October	$3,655.86
Amount Paid on Drugs Furnished during October	761.47
Amount Paid to Hospitals during October	602.58
Amount Paid to Dentists during October	499.54

—*Journal of Kansas Medical Society,* (Jan. 1940)

COUNTY AND PERSONAL ACTIVITIES

Physicians' Federal Income Tax—1940, is thoroughly explained in the *Journal of the American Medical Association* for January 20, page 254.

* * *

W. A. Altemeier, M.D., and H. C. Jones, M.D., of Detroit, were co-authors of "Experimental Peritonitis" which appeared in the January 6 issue of *The Journal of the American Medical Association.*

* * *

State Health Commissioner H. Allen Moyer announces the appointment of Carleton Dean, M.D., formerly of Charlevoix, as Deputy Commissioner, in Charge of Bureau of Local Health Services, to fill the vacancy left by the resignation of Albert McCown, M.D., as of January 1, 1940. Congratulations, Doctor Dean!

* * *

The Board of Trustees of Butterworth Hospital, Grand Rapids, announce the appointment of the following officers for 1940-41: Chief of Staff, Leland M. McKinlay, M.D., Vice Chief, Leon C. Bosch, M.D., Chief of Medicine, Abel J. Baker, M.D., Chief of Surgery, G. Howard Southwick, M.D., Chief of Obstetrics and Gynecology, Harrison S. Collisi, M.D., Chief of Pediatrics, L. J. Schermerhorn, M.D., and Chief of Eye, Ear, Nose and Throat, Henry H. Blackburn, M.D.

* * *

The War Department has announced an examination March 18 to 22, inclusive, for the purpose of qualifying candidates for appointment as First Lieutenants in the Medical Corps, Regular Army, to fill vacancies occurring during the remainder of the present fiscal year. Due to expansion of the Air Corps and Coast Defenses, there will be considerably more than the usual number of vacancies. Full information and application blanks will be furnished upon request addressed to The Adjutant General, War Department, Washington, D. C., and received before March 2, 1940.

* * *

The Michigan Pathological Society held its annual meeting at the University Hospital on December 9, 1939. The afternoon was devoted to demonstrations in the pathological laboratories of the Hospital. The following were elected to office in the Society for the coming year: W. L. Brosius, M.D., President, Detroit; J. A. Kasper, M.D., President-Elect, Detroit; D. C. Beaver, M.D., Secretary-Treasurer, Detroit; O. A. Brines, M.D., Detroit, and G. L. Bond, M.D., Grand Rapids, Councilors. O. W. Lohr, M.D., Saginaw, is the retiring president.

* * *

The staff of the Mount Carmel Mercy Hospital of Detroit held its Annual Clinic Day and Banquet in Detroit on Wednesday, January 31. Speakers and topics were as follows: O. R. Yoder, M.D., Ypsilanti, "Management of the Neurotic Patient in Private Practice"; E. L. Sevringhaus, M.D., Madison, Wis., R. L. Schaefer, M.D., and Robert C. Moehlig, M.D., Detroit, round table discussion on "Adaptation of Glandular Therapy by General Practitioner"; S. D. Kramer, M.D., Brooklyn, "Virus Diseases in Everyday Practice"; Frank Riggall, M.D., of Arkansas, "Pre-operative and Post-operative Management of Biliary Disease"; Norman F. Miller, M.D., Ann Arbor, "Obstetrics in General Practice."

Louis J. Gariepy, M.D., Detroit, was Toastmaster at the dinner, Statler Hotel. Speakers at the banquet included Ralph H. Pino, M.D., President of the Wayne County Medical Society; and Stanley W. Insley, M.D., Chairman of the Program Committee. The main address was given by Rev. Father Charles E. Coughlin, who spoke on the subject "Government Medical Care—How Far Should It Go?"

HAVE YOU MOVED?

It is important that the mailing list of THE JOURNAL of the Michigan State Medical Society be kept up to date and accurate. Members are invited to help us in this work. When and if you change your mailing address, please drop a card to THE JOURNAL, giving your new address. If you would like to have your copy of THE JOURNAL sent to your home instead of your office (or vice versa), write the Executive Office, 2020 Olds Tower, Lansing. Please submit changes in address promptly to assist THE JOURNAL in avoiding delay in making mailing list revisions. We desire to have THE JOURNAL reach you each month without delay.

The following Health Talks were released for broadcast over radio station CKLW during January:

January 5, 1940, 7:30 p. m. "Preservation of Good Health" by Wm. J. Stapleton, Jr., M.D., Detroit.

January 12, 1940, 7:30 p. m. "Diseases of the Liver and Gall-Bladder" by Charles E. Lemmon, M.D., Detroit.

January 19, 1940, 7:30 p. m. "Appendicitis" by Clifford D. Benson, M.D., Detroit.

January 26, 1940, 7:30 p. m. "Scarlet Fever" by Edward A. Wishropp, M.D., Detroit.

February 2, 1940, 7:30 p. m. "Child Spacing and Its Relation to the Mother's Health" by Harold Mack, M.D., Detroit.

* * *

Doctor, remember your particular friends, the exhibitors, at your annual convention, when you have need of equipment, appliances, medicinal supplies and service. Here are ten more of the firms which helped make the 1939 Convention such a great success:

Gilbert Specialties Company, Michigan City, Ind.
Hack Shoe Company, Detroit
Hanovia Chemical & Mfg. Company, Newark
J. F. Hartz Company, Detroit
H. J. Heinz Company, Pittsburgh
High Tension Electric Company, New York
Holland-Rantos Company, New York
Horlick's Malted Milk Corporation, Racine
G. A. Ingram Company, Detroit
Jones Metabolism Equipment Company, Chicago

* * *

Ophthalmologists, Attention! Beware of a man who is travelling around the country purchasing glasses, especially from oculists, usually offering for same a check in the amount of $30.00. He usually endorses the check in a very rough, plainly legible hand and signs it "W. C. Curran"; he always asks for the difference between the amount of the check and the price of the glasses *in cash* (but he does not call for the spectacles).

This man simulates a farmer and usually has on the check a notation about cows, corn, hogs, etc. He is about 5 feet 9 to 10 inches tall, weighs about 155 pounds, has light sandy hair, blue eyes, is smooth

shaven with a ruddy complexion, and is approximately 49 years old.

The complaint concerning this man has been received from Herbert D. Kimberlin, M.D., Trenton Trust Building, Trenton, Missouri, in behalf of himself and Dr. R. C. Pearson of Maryville, Mo. Please inform these physicians at once (telegraph collect) or the sheriff of Nodaway County, or Grundy County, Missouri, if "W. C. Curran" calls on you.

* * *

COUNCIL AND COMMITTEE MEETINGS

Thursday, December 28—Syphilis Control Committee—Statler Hotel, Detroit—5:00 p. m.

Wednesday, January 3—Public Relations Committee—Porter Hotel, Lansing—3:00 p. m.

Friday, January 12—Cancer Committee—Woman's League Bldg., Ann Arbor—6:30 p. m.

Friday, January 12—Finance Committee of The Council—Statler Hotel, Detroit—7:00 p. m.

Saturday, January 13—County Societies Committee of The Council—Statler Hotel, Detroit—8:00 a. m.

Saturday, January 13—Publication Committee of The Council—Statler Hotel, Detroit—8:00 a. m.

Saturday, January 13 and Sunday, January 14—10:00 a. m., Midwinter Meeting of The Council, Hotel Statler, Detroit.

Wednesday, January 17—Child Welfare Committee—State School for Deaf, Flint—12:15 p. m.

Friday, January 19—Maternal Health Committee—Statler Hotel, Detroit—12:15 p. m.

Wednesday, February 7—Syphilis Control Committee—Hotel Olds, Lansing—5:00 p. m.

* * *

COUNTY MEDICAL SOCIETY MEETINGS

Alpena County—September—Speakers: Mr. Adolph "Germany" Shultz and Mr. Leo Ford. October—Speaker: Clifford H. Keene, M.D., of Ann Arbor. November—Speakers: Richard Freyberg, M.D., and John Sheldon, M.D., of Ann Arbor. December—Speakers: J. T. Jerome, M.D., and Mark Osterlin, M.D., of Traverse City.

Calhoun County—January 2—Battle Creek—Speaker: David Steel, M.D., Cleveland.

Dickinson-Iron—January 11—Iron Mountain—Speaker: Wm. S. Jones, M.D., Menominee. Guests: Judges of Probate, Welfare Directors and Health Committees of the Boards of Supervisors from Dickinson and Iron Counties.

Eaton County—December 14—Charlotte—Speaker: Cyrus Sturgis, M.D., Ann Arbor.

Gratiot-Isabella-Clare—January 18—Alma—Speaker: Hewitt Smith, M.D., Lansing.

Ingham County—January 16—Lansing—Speaker: Mr. Ben East of Grand Rapids.

Ionia-Montcalm—January 9—Stanton—Speaker: A. J. Baker, M.D., Grand Rapids.

Jackson and Hillsdale Counties—January 16—Jackson—Speakers: Henry R. Carstens, M.D., Detroit; L. Fernald Foster, M.D., Bay City; Wm. J. Burns and J. D. Laux of Lansing,

Kalamazoo County—December 19—Kalamazoo—Speaker: Paul Harrison, M.D., Kalamazoo. January 16—Kalamazoo—Speaker: Russell D. Herrold, M.D., Chicago.

Kent County—January 10—Grand Rapids—Speakers: Gordon W. Balyeat, M.D., R. J. Hutchinson, M.D., and Jay Venema, M.D., of Grand Rapids.

St. Clair County—December 26—St. Clair—Annual Meeting, Speaker: Jesse Wolcott, Member of Congress. January 23—Port Huron—Speaker: F. E. Schmidt, M.D., Chicago.

Shiawassee County—January 18—Owosso—Joint meeting with pharmacists of Shiawassee County.

Wayne County—December 18—Detroit—C. A. Mills,

M.D., Cincinnati. January 8—Detroit—M. A. Blankenhorn, M.D., Cincinnati. January 15—Detroit—W. F. Braasch, M.D., Rochester, Minn. January 22—Detroit—Fred W. Rankin, M.D., Lexington, Kentucky. January 29—Detroit—E. L. Sevringhaus, M.D., Madison.

West Side Medical Society (Detroit)—January 18—Detroit—Speakers: Robert L. Schaefer, M.D., A. J. Lehman, M.D., and P. F. Morse, M.D.

Michigan Society of Neurology and Psychiatry—January 11—Detroit—Speakers: Theophil Klingman, M.D., Ann Arbor; John M. Dorsey, M.D., Detroit, Lowell S. Selling, M.D., Detroit; and Milton H. Erickson, M.D., Eloise.

"State Society Nights" were held by Oakland County on January 22 and by Macomb County on February 5 at which "Michigan Medical Service" was thoroughly explained by officers of the Michigan State Medical Society. Among the MSMS officers who attended were Henry R. Carstens, M.D., Detroit; L. Fernald Foster, M.D., Bay City; Executive Secretary Wm. J. Burns, and Mr. J. D. Laux of Michigan Medical Service. The meetings were arranged by H. L. Morris, M.D., Detroit, member of the Public Relations Committee.

* * *

New Officers of County Medical Societies

Alpena-Alcona-Presque Isle:
President: F. J. O'Donnell, M.D., Alpena
Vice President: H. J. Burkholder, M.D., Alpena
Secretary: E. S. Parmenter, M.D., Alpena
Delegate: W. E. Nesbitt, M.D., Alpena
Alternate Delegate: A. R. Miller, M.D., Harrisville

Bay-Arenac-Iosco-Gladwin:
President: Robert H. Criswell, M.D., Bay City
President-Elect: R. N. Sherman, M.D., Bay City
Secretary-Treasurer: L. Fernald Foster, M.D., Bay City
Medico-Legal Officer: E. A. Wittwer, M.D., Bay City
Delegates: C. L. Hess, M.D., and V. H. Dumond, M.D., Bay City
Alternate Delegates: Fred Drummond, M.D., Kawkawlin; and Joseph C. Grosjean, M.D., Bay City

Berrien County:
President: Scott Moore, M.D., Niles
Vice President: A. F. Bliesmer, M.D., St. Joseph
Secretary-Treasurer: R. C. Conybeare, M.D., Benton Harbor
Delegate: Wm. Ellet, M.D., Benton Harbor
Alternate Delegate: Fred Henderson, M.D., Niles

Calhoun County:
President: A. M. Giddings, M.D., Battle Creek
President-Elect: Harry F. Becker, M.D., Battle Creek
Vice President: John E. Cooper, M.D., Battle Creek
Secretary-Treasurer: Wilfrid Haughey, M.D., Battle Creek
Delegate: Harvey Hansen, M.D., Battle Creek
Alternate Delegate: Geo. W. Slagle, M.D., Battle Creek

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Vice President: J. K. Hickman, M.D., Dowagiac
Secretary-Treasurer: U. M. Adams, M.D., Marcellus
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Alternate Delegate: K. C. Pierce, M.D., Dowagiac

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Secretary: L. J. Hakala, M.D., Sault Ste. Marie
Delegate: B. T. Montgomery, M.D., Sault Ste. Marie
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Secretary: E. B. Andersen, M.D., Iron Mountain

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Vice President: H. A. Pinkerton, M.D., Ironwood
Secretary-Treasurer: F. L. S. Reynolds, M.D., Ironwood
Delegate: W. E. Tew, M.D., Bessemer
Alternate Delegate: D. C. Eisele, M.D., Ironwood

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Secretary: I. H. Zielke, M.D., Traverse City

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President-Elect: H. W. Wiley, M.D., Lansing
Secretary: R. J. Himmelberger, M.D., Lansing
Treasurer: J. H. Albers, M.D., East Lansing
Delegates: C. F. DeVries, M.D., R. S. Breakey, M.D., T. I. Bauer, M.D., all of Lansing
Alternate Delegates: W. H. Welch, M.D., Lansing; O. H. Bruegel, M.D., East Lansing; and E. H. Foust, M.D., Lansing

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President-Elect: L. L. Marston, M.D., Lakeview
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Delegate: W. L. Bird, M.D., Hesperia
Alternate Delegate: C. H. Peabody, M.D., Lake Odessa

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President: Paul W. Willits, M.D., Grand Rapids
President-Elect: P. L. Thompson, M.D., Grand Rapids
Vice President: Norman Vann, M.D., Grand Rapids
Secretary-Treasurer: Frank L. Doran, M.D., Grand Rapids
Delegates: A. B. Wenger, M.D., Carl F. Snapp, M.D., A. B. Smith, M.D., George Southwick, M.D., and Paul Kniskern, M.D., Grand Rapids
Alternate Delegates: Wm. Bettison, M.D., A. J. Baker, M.D., Leon DeVel, M.D., J. D. Miller, M.D., and Wm. J. Butler, M.D., Grand Rapids

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President: D. J. O'Brien, M.D., Lapeer
Vice President: K. W. Dick, M.D., Imlay City
Secretary-Treasurer: H. M. Best, M.D., Lapeer
Delegate: D. J. O'Brien, M.D.
Alternate Delegate: H. M. Best, M.D.

Livingston County:
President: H. G. Huntington, M.D., Howell
Secretary-Treasurer: H. C. Hill, M.D., Howell
Delegate: D. C. Stephens, M.D., Howell
Alternate Delegate: D. A. Cameron, M.D., Brighton

Luce County:
President: Wm. R. Purmort, Jr., M.D., Newberry
Vice President: Geo. F. Swanson, M.D., Newberry
Secretary-Treasurer: Matthew A. Surrell, M.D., Newberry
Delegate: Henry E. Perry, M.D., Newberry
Alternate Delegate: R. E. Spinks, M.D., Newberry

Macomb County:
President: Russell E. Lynch, M.D., Centerline
Vice President: Russell F. Salot, M.D., Mt. Clemens
Secretary: D. Bruce Wiley, M.D., Utica
Treasurer: E. W. Caster, M.D., Mt. Clemens
Delegate: D. Bruce Wiley, M.D., Utica
Alternate Delegate: A. B. Bower, M.D., Armada

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President: Lars W. Switzer, M.D., Manistee
Vice President: E. B. Miller, M.D., Manistee
Secretary-Treasurer: C. L. Grant, M.D., Manistee
Delegate: E. A. Oakes, M.D., Manistee
Alternate Delegate: Lars W. Switzer, M.D., Manistee

Marquette-Alger:
President: R. F. Berry, M.D., Marquette
Vice President: W. C. Lambert, M.D., Marquette
Secretary-Treasurer: D. P. Hornbogen, M.D., Marquette
Delegate: V. Vandeventer, M.D., Ishpeming
Alternate Delegate: R. A. Burke, M.D., Palmer

Mason County:
President: Robert Farrier, M.D., Ludington
Secretary: Ivan L. Hunt, M.D., Scottville

Mecosta-Osceola:
President: J. A. White, M.D., Morley
Secretary-Treasurer: Glenn Grieve, M.D., Big Rapids

Menominee County:
President: H. T. Sethney, M.D., Menominee
Vice President: J. T. Kaye, M.D., Menominee
Secretary-Treasurer: W. S. Jones, M.D., Menominee
Delegate: H. T. Sethney, M.D., Menominee
Alternate Delegate: S. C. Mason, M.D., Menominee

Muskegon County:
President: E. O. Foss, M.D., Muskegon
President-Elect: R. H. Holmes, M.D., Muskegon
Secretary-Treasurer: L. E. Holly, M.D., Muskegon
Delegates: E. O. Foss, M.D., and E. N. D'Alcorn, M.D., Muskegon
Alternate Delegates: L. E. Holly, M.D., and S. W. Hartwell, M.D., Muskegon
Medico-Legal Advisory: Geo. LeFevre, M.D., Muskegon

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President: F. W. Lee, M.D., Fairview
Vice President: Joseph Egle, M.D., Gaylord
Secretary-Treasurer: C. G. Clippert, M.D., Grayling
Delegate: C. R. Keyport, M.D., Grayling
Alternate Delegate: C. G. Clippert, M.D., Grayling

Oceana County:
President: A. R. Hayton, M.D., Shelby
Vice President: Charles Flint, M.D., Hart
Secretary-Treasurer: Fred A. Reetz, M.D., Shelby
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Ottawa County:
President: Charles E. Long, M.D., Grand Haven
Vice President: J. W. Verduin, M.D., Grand Haven
Secretary-Treasurer: D. C. Bloemendaal, M.D., Zeeland
Delegate: A. E. Stickley, M.D., Coopersville
Alternate Delegate: R. H. Nichols, M.D., Holland

Saginaw County:
President: F. O. Novy, M.D., Saginaw
President-Elect: Lloyd A. Campbell, M.D., Saginaw
Secretary-Treasurer: Dale E. Thomas, M.D., Saginaw

St. Clair County:
President: Charles F. Thomas, M.D., Port Huron
President-Elect, W. H. Boughner, M.D., Algonac
Secretary-Treasurer: J. H. Burley, M.D., Port Huron
Delegate: A. L. Callery, M.D., Port Huron

Washtenaw County:
President: John S. DeTar, M.D., Milan
President-Elect: Wm. M. Brace, M.D., Ann Arbor
Secretary-Treasurer: R. K. Ratliff, M.D., Ann Arbor

IN MEMORIAM

W. H. Ditmars, M.D.

W. H. Ditmars, of Jonesville, Michigan. Born in North Adams, November 28, 1873. Attended Hillsdale College. Later he taught school. In June, 1897, graduated from the Detroit College of Medicine. Spent his entire professional life in Jonesville. Died at the age of sixty-six years.

Charles E. Greene, M.D.

Charles E. Greene, of Owosso, Michigan, born near Sand Lake, Rensselaer county, N. Y., May 8, 1860. Attended State Normal College at Albany, N. Y., University of Michigan Medical School and Long Island College Hospital. M.D. 1890. Practiced in Riley Center, St. Clair county, for fifteen years and then at Richmond, Michigan, for ten years. Died at the age of seventy-nine from pericolitis and chronic inflammatory diverticulitis of the colon. As a State Senator from 1925 to 1929 he was chairman of the Public Health Committee and a fine exponent of intelligent health measures. He was the father of Dr. I. W. Greene of Owosso, who has been very prominent in the Michigan State Medical Society.

John E. Handy, M.D.

John E. Handy, of Caro, Michigan. Born in Mountbridge, Ontario, September 23, 1858. Graduated from the Detroit College of Medicine 1887. Started practicing in Watrousville. Transferred his office to Caro in 1906 and continued to practice there until his death. Was elected Emeritus Member of the Michigan State Medical Society in 1937. Doctor Handy was the dean of the medical profession of Tuscola County, at the time of his death. He was appointed by Governor Comstock to the State Board of Registration in Medicine, a position which he held for three years, resigning in 1936. Died at the age of eighty-one years from a heart attack.

READING NOTICES

ANTITETANUS IMMUNIZATION

All soldiers in France are now required by law to be given antitetanus immunization. The immunity varies considerably. It may drop to a minimum level within ninety days after the second injection or retain a high level over a period of years. This basal immunity, which is probably lifelong, is rapidly and markedly accelerated at any time with an injection of toxoid.

Rogers (Bull. New York Acad. Med., 15:553, August, 1939) has suggested that active tetanus immunization should be given to those who are sensitive to horse serum, to asthmatic patients and other allergic individuals if they are in occupations or indulge in avocations which carry with them danger of injury. He includes in an optional group children, especially those living in the country or those who ride, and nonallergic individuals engaged in hazardous occupations or avocations.

Tetanus Toxoid, Alum Precipitated, Lilly, is supplied in packages for single and multiple immunizations. Simultaneous immunization to diphtheria may be accomplished by using Diphtheria Toxoid-Tetanus Toxoid Combined, Alum Precipitated, Lilly.

PSYCHOLOGICAL ASPECTS OF COD LIVER OIL ADMINISTRATION

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silverplated spoon (particularly if the plating is worn), a glass spoon has an advantage.

On account of its higher potency in Vitamins A and D, Mead's Cod Liver Oil Fortified with Percomorph Liver Oil may be given in one-third the ordinary cod liver oil dosage, and is particularly desirable in cases of fat intolerance.

STUDY OF FILTERABLE VIRUS DISEASES

Establishment of a new laboratory for the study of filterable virus diseases, in the treatment and prevention of which science is believed to be at the threshold of an important advance, is announced by the Squibb Biological Laboratories.

Dr. Raymond C. Parker, biologist of the Rockefeller Institute for Medical Research, has been appointed to head the laboratory, which will operate as a unit of the Biological Division of E. R. Squibb and Sons at New Brunswick, N. J. The new building is a continuation of a program of expansion which began in the fall of 1938 with the dedication to pure science of the $750,000 laboratory of the Squibb Institute for Medical Research.

Among the common diseases caused by filterable viruses, to be studied, Dr. Anderson pointed out, are smallpox, rabies, equine encephalitis, measles, chicken pox, poliomyelitis, and the common cold. No specific product for the prevention of four of these diseases—the common cold, poliomyelitis, chicken-pox, and measles—is now available.

"Who's Who in the Hack Organization" is the subject of a new series of advertisements commencing this month in THE JOURNAL of the Michigan State Medical Society.

An old and tried friend of the Michigan State Medical Society, the Hack Shoe Company, each month will present a brief biographic sketch of a different member of its staff. Drawn from the viewpoint of the individual's shoe fitting experience, the series is designed better to acquaint the doctors with the people to whom they entrust the fitting of their patients' feet.

As the senior Mr. Hack has phrased it, "The proper filling of shoe prescriptions is a process that requires the exercise of a great deal of judgment. Thus, we believe that the members of the Michigan State Medical Society have the right to know all about our staff and its experience."

Hack shoes were exhibited at the 1940 meeting of the American Academy of Orthopædic Surgeons in Boston, January 22 to 25.

THE DOCTOR'S LIBRARY

Acknowledgement of all books received will be made in this column and this will be deemed by us a full compensation of those sending them. A selection will be made for review, as expedient.

MEDICOLEGAL AND INDUSTRIAL TOXICOLOGY. Criminal Investigation. Occupational Diseases. By Henry J. Eilmann, Ph.D., Director of Physicians' Laboratory Service of Toledo, Ohio; Lecturer in Bacteriology and Histology, Mary Manse College of Toledo. Published by The Blakiston Company, Philadelphia. Price $3.00.

The author considers each industrially used or commonly found drug or chemical and discusses its uses, symptoms of poisoning from it, and means of detecting such poisons as well as suggestions for treatment of the resulting injury. A short but very well written section on criminal investigation of this type of poisoning is included. Then in a very brief manner he discusses medicolegal examinations of miscellaneous natures from death caused by gases, food poisonings and physical means.

LANE MEDICAL LECTURES: Viruses and Virus Diseases. By Thomas M. Rivers, M.D., Sc.D., Director, Hospital of The Rockefeller Institute for Medical Research, New York City. Stanford University Publications, University Series, Medical Sciences, Volume IV, Number I. Published by Stanford University Press, Stanford University, California. London: Humphrey Milford, Oxford University Press. Price: Cloth $2.50; Paper $1.75.

Thomas M. Rivers, M.D., of the Rockefeller Institute, has joined the list of medical greats who have delivered the Lane Medical Lectures at Stanford University. These are compiled into a monograph under the above title and provide a complete illuminating discussion of the theoretical and the practical side of virus disease. It is unfortunate that the quality of the paper used does not show off to the best advantage the beautiful photomicrographs which illustrate the text. Such a review of a class of infections which is becoming more and more prominent in the practice of medicine is well worth reading.

DISEASES OF THE EAR, NOSE AND THROAT. Principles and Practice of Otorhinolaryngology. By Francis L. Lederer, B.Sc., M.D., F.A.C.S., Professor and Head of the Department of Laryngology, Rhinology and Otology, University of Illinois College of Medicine, Chicago; Chief of the Otolaryngological Service, Research and Educational Hospital. Second Revised Edition. Illustrated with 765 Halftone and Line Engravings on 463 Figures and 16 Full-page Color Plates. Published by F. A. Davis Company, Philadelphia. Price $10.00.

The arrangement in columns in this book makes it very easy reading. It is essentially a text in diagnosis of these diseases containing many illustrations, a number of which are in color. It clarifies in the mind, the anatomy of the regions considered. An excellent continuity of etiology and symptomatology combined with the above mentioned advantages makes it a completely worthwhile text. The section on treatment is not as complete as the diagnostic section.

MATERIA MEDICA, Drug Administration and Prescription Writing. By Oscar W. Bethea, M.D., Ph.G., Ph.M., F.C.S., F.A.C.P., Professor of Clinical Medicine, Tulane School of Medicine; Professor of Therapeutics, Tulane Graduate School of Medicine; Senior Physician, Southern Baptist Hospital (New Orleans); Senior Visiting Physician, Charity Hospital of Louisiana; Member Revision Committee U. S. Pharmacopœia, Etc. Fifth Revised Edition. Published by F. A. Davis Company, Philadelphia, 1939. Price $5.00.

A new edition has been made to conform with the new Pharmacopœia and National Formulary. There has been an addition of much new material and many changes in the text. Essential information regarding the drugs which the practitioner would be likely to

use in writing a prescription are discussed in a concise, informative manner. Included by the author, are the common prescriptions including these drugs and the uses for which they are indicated. A very fine section on the art of writing prescriptions is an essential part of the book. It is a very complete volume. Many tables, lists, and examples are included. The clinical index is also a valuable part of the book. In order to bring it up to the minute a supplement is included of the newest accepted remedies.

PRACTICAL OBSTETRICS. By P. Brooke Bland, M.D., Emeritus Professor of Obstetrics, Jefferson Medical College; Consulting Obstetrician, Jefferson Medical College Hospital, Philadelphia, Pa.: and Thaddeus L. Montgomery, M.D., Clinical Professor of Obstetrics, Jefferson Medical College, Philadelphia; Pa. Third Revised Edition. Illustrated with 502 Engravings including 27 Colored Plates. Published by F. A. Davis Company, Philadelphia, 1939. Price $8.00.

This third edition of Drs. Bland and Montgomery's "Practical Obstetrics" is outstanding for the numerous cuts and especially for the splendid colored plates. With 502 pictures it provides an easily read textbook in obstetrics for the practitioner. The many practical points included make it valuable for general use.

GYNECOLOGY. Medical and Surgical. By P. Brooke Bland, M.D., F.A.C.S., Professor Emeritus of Obstetrics, The Jefferson Medical College, Philadelphia; Consulting Obstetrician to the Jefferson Medical College Hospital, Philadelphia; Consulting Obstetrician to the Philadelphia Lying-In Hospital; Formerly Associate Professor of Gynecology in The Jefferson Medical College and Visiting Gynecologist to St. Joseph's Hospital, Philadelphia, Etc. Assisted by Arthur First, M.D., Associate in Obstetrics, The Jefferson Medical College Hospital, Philadelphia; Associate in Obstetrics, Mt. Sinai Hospital, Philadelphia; Assisting Gynecologist, Stetson Hospital, Philadelphia. Third Revised Edition, with 445 illustrations, mostly original, including 31 full page plates in color. Published by F. A. Davis Company, Philadelphia, 1939. Price $8.00.

This is the third edition of a work first published in 1924. It has been almost all re-written, and contains 442 illustrations, many of them in color. The chapters on "Symptoms," and "Diagnosis," and "Surgical Procedure" are especially recommended. Also included is a fine long list of referred reading.

PROCTOLOGY FOR THE GENERAL PRACTITIONER. By Frederick C. Smith, M.D., M.Sc., (Med.); F.A.P.S., Proctologist to St. Luke's and Children's Hospital, Philadelphia; formerly Associate in Proctology, Graduate School of Medicine, University of Pennsylvania. Illustrated with 142 Half-tones and Line Engravings and Three-Color Plates. Published by F. A. Davis Company, Philadelphia, 1939. Price $4.50.

A very practical and easily read volume which outlines simply and concisely the symptoms, pathology and office treatment of various proctological conditions which are seen frequently by the general practitioner. The discussion of anesthetics is very good and the various technics are described and evaluated. There are many illustrations and diagrams.

HEADACHE AND HEAD PAINS—A Ready Reference Manual for Physicians. By Walton Forest Dutton, M.D., Formerly Medical Director, Polyclinic and Medico-Chirurgical Hospitals, Graduate School of Medicine, University of Pennsylvania; Visiting Physician to the Northwest Texas Hospital; Visiting Physician to the St. Anthony's Hospital; Director, Medical Research Laboratories, Amarillo, Texas. Published by F. A. Davis Company, Philadelphia, 1939. Price $4.50.

This book discusses all the affections causing headaches and head pains numbering over two hundred. The author then discusses each cause and its action. Part of the book is devoted to lists of remedies for the relief of headache produced by any certain general condition.

DIAGNOSTIC SIGNS, REFLEXES AND SYNDROMES (Standardized). By William Egbert Robertson, M.D., F.A.C.P., Visiting Physician, Medical Division, Philadelphia General Hospital; Visiting Physician, St. Luke's and Children's Hospital and Northeastern Hospital; and Harold F. Robertson, B.S., M.D., F.A.C.P., Instructor

in Medicine, University of Pennsylvania; Assistant Visiting Physician, Medical Division, Philadelphia General Hospital and Methodist Hospital. Published by F. A. Davis Company, Philadelphia, 1939. Price $3.50.

This is more than a mere dictionary of names of various signs and syndromes. It is cross indexed under various types of conditions which give the busy practitioner diagnostic aid in a difficult case. For the man who does a lot of reading it is a "must book" in order to interpret the confusing names used by the various writers to describe various reflexes, signs and syndromes.

Wisconsin has 2,909,000 population. Of these 175,000 people are receiving direct relief; 195,000 exclusive of administration employees are supported by W.P.A. employment; 95,000 people are in families receiving one of the three Social Security aids. Representing all, 16 per cent of the population.—*Wisconsin Medical Journal* (Jan. 1940).

"State medicine is forced medicine. You will take it and like it. It is the doctor's dole, the patient's subsidy. The patient will do what he's told, the doctor will do what he's told. And the telling will be done by an office holder who wouldn't know what to do with a patient if he had one, but thinks he can tell the specially trained man how to do what he himself cannot do."—TERRY M. THOMPSON, M.D., President, Medical Society of the State of New York.

Almost forty thousand less deaths from birth to forty years old between 1918 and 1938. There were twelve thousand deaths from the flu in 1918 to be deducted. There were twenty-three thousand more deaths in 1938 than 1918 from the ages forty up. Twenty-seven hundred deaths from the flu in 1918 in this group. There were five thousand less deaths of tuberculosis, four thousand less of infantile diarrhea one thousand less from diphtheria, five hundred less from whooping cough, five hundred less from typhoid fever, and thirteen less from small pox, there being fourteen in 1918 and one in 1938.—*Chicago Medical Society Bulletin* (Dec. 23, 1939).